

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5876 CERTIFICATE OF DEATH

Reg. Dist. No.

05859

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Marylnd		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		d. STREET ADDRESS Defence Highway		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Fred	Middle Faulkner	Last Acers	4. DATE OF DEATH	Month May	Day 10	Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-22-87	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 71	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Louis Acers			14. MOTHER'S MAIDEN NAME Mary Rifenbark					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/>) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Chlora E. Acers		Address Same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Negrocardial infarction INTERVAL BETWEEN ONSET AND DEATH DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease 10 yr DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Colmar Manor	(County) Md.	(State) Colmar Manor, Md.	
21. I certify that I attended the deceased from _____, 1947 to 1959, that I last saw the deceased alive on 5-10-1959, and that death occurred at 6:55 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Albert Roth M.D. ADDRESS (Street, city or town, state) Beverly DATE SIGNED 5-11-59								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/59		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		22d. LOCATION (City, town, or county) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Avenue		24a. REC'D BY REGISTRAR DATE MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kline		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5877 CERTIFICATE OF DEATH

Reg. Dist. No.

05860

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Maryland</i>		b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale, Maryland</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale, Maryland</i>		d. STREET ADDRESS <i>5005 Riverdale Rd.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Leland Memorial Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mae S. Adams</i>		First	Middle	Last	4. DATE OF DEATH Month <i>5</i>	Day <i>12</i>	Year <i>1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>April 11, 1885</i>		9. AGE (In years last birthday) <i>74 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Harry Fetterman</i>		14. MOTHER'S MAIDEN NAME <i>Mary E.</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>420.0</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Address</i>	
17. INFORMANT <i>Mr Edna Bentner Riverdale Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO <i>Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>arteriosclerotic Heart Disease</i> (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 11, 1959</i> , to <i>May 12, 1959</i> , that I last saw the deceased alive on <i>May 11, 1959</i> , and that death occurred at <i>343 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>L W Malin M.D.</i>				ADDRESS (Street, city or town, state) <i>Riverdale, Md</i> DATE SIGNED <i>May 12, 1959</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>cremation</i>		22b. DATE THEREOF <i>5/12/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Indiana</i>		22d. LOCATION (City, town, or county) (State) <i>Pennsylvania</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Jackson Jr. Hyattsville Md</i>		ADDRESS <i>ADDRESS</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Albert S. Kraus</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

CERTIFICATE OF DEATH

DEATH CERTIFICATE
MICHIGAN STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No

05861

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~severable~~ papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 3 months and 9 days		d. STREET ADDRESS Washington		b. COUNTY D. C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 X-3					
3. NAME OF DECEASED (Type or print) Robert		First Samuel Middle Alsop		4. DATE OF DEATH Month 5 Day 12 Year 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12/21/95	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR, IF UNDER 24 HRS. Months - Days - Hours - Min. -				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Treasury Dept.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY: USA			
13. FATHER'S NAME Moses Alsop				14. MOTHER'S MAIDEN NAME Eunice Alsop					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. 17. INFORMANT Address Unknown Decedent					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1930 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis; diabetes mellitus								INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour p. m.	Month 19	Day 2/6	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Woodford, Virginia	(County) Glenn Dale Hospital	(State) 5/12/59		
21. I certify that I attended the deceased from 5/12 , 19 59 , to 5/12 , 19 59 , that I last saw the deceased alive on 5/12 , 19 59 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Glenn Dale Hospital	DATE SIGNED 5/12/59
ACTUAL SIGNATURE Moe Weiss		M.D.							
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.							
22a. BURIAL/CREMATION, REMOVAL (Specify) 5-13-1959		22b. DATE THEREOF 5-13-1959		22c. NAME OF CEMETERY OR CREMATORIUM Beulah Bapt. Cem.		22d. LOCATION (City, town, or county) Woodford, Virginia		(State) 5/12/59	
23. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARVIS				ADDRESS 1432 - You St. N.W.		24a. REC'D BY REGISTRAR Cathleen S. Turner	24b. REGISTRAR'S SIGNATURE Cathleen S. Turner		
DATE MAY 15 '59									

STATE DEPARTMENT OF HEALTH - DIVISION OF DEATH
CERTIFICATE OF DEATH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05862

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		5867 HYATTSTVILLE, Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		WASH. D. C.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb HYATTSTVILLE 5 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Carroll Manor - 4922 La Salle Rd.		d. STREET ADDRESS		5000 Cathedral Ave. N.W.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				e. DATE OF DEATH		Month	Day	Year
3. NAME OF DECEASED (Type or print)		First	Middle	Last		May	24	1959
4. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS		
Female		White		AUG. 29, 1877	81 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
HOUSEWIFE		Farm Owner		Villa Grove, Illinois		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
George Henson		Elizabeth Sargent.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		305-40-2793 Mother M. Francis Michael 4922 La Salle Pl.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Respiratory depression INTERVAL BETWEEN ONSET AND DEATH								
DUE TO (b) Multiple emboli to brain								
DUE TO (c) Lay-standing arterioleclerotic thrombopathy								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
One standing gonococcal urethritis. Partial inter. obstr. - findings.								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Aug</u> , 1959, to <u>Aug 29</u> , 1959, that I last saw the deceased alive on <u>Aug 24</u> , 1959, and that death occurred at <u>3540 P.M.</u> from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <u>432 Harvard St., Silver Spring, Md.</u> DATE SIGNED <u>Richard P. Delaney</u>								
ACTUAL SIGNATURE <u>Richard P. Delaney</u>		M.D. <u>432 Harvard St., Silver Spring, Md. 20910</u>						
PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY</u>		432 Harvard St., Silver Spring, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 5/26/59		22b. DATE THEREOF <u>5/26/59</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>CAMARGO, ILLINOIS</u>		22d. LOCATION (City, town, or county) (State) <u>CAMARGO, ILLINOIS</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Devlin's Sons</u>		ADDRESS <u>1756 Pa. Ave., N.W. DC</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 FilmG243 6-2-59 et

05863

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jamestown Rd. 5840				d. STREET ADDRESS 15840 Jamestown Rd.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE		First MINNIE	Middle M.	Last A NDERSON	4. DATE OF DEATH Month May	Day 21	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876 8 April 1877		9. AGE (In years last birthday) 83 7/8 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Paris				14. MOTHER'S MAIDEN NAME Katherine Boggan Grogan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT May A. Gatens		Address Mary Gatens 15840 Jamestown Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176.1 DUE TO Carcinoma Vagina Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized abdominal carcinomatosis DUE TO no (c) no							
INTERVAL BETWEEN ONSET AND DEATH no							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) no							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no					
20c. TIME OF INJURY Month, Day, Year Hour a. m. no 19 p. m. no		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2 , 1957 to May 21 , 1957, that I last saw the deceased alive on May 20 , 1957, and that death occurred at 520 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 301 Constitution St. E					
ACTUAL SIGNATURE AK Bowie MD		DATE SIGNED 5/21/57					
PHYSICIAN'S NAME (Type) AK BOWIE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 23 May 1959		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cem.		22d. LOCATION (City, town, or county) Bladensburg	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 4 th & Mass Av N E		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5878

05864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b D.O.A.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			4. DATE OF DEATH May 18 1959		
3. NAME OF DECEASED (Type or print) Elsie Hazel Baldwin			First	Middle	Last
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 9, 1905	9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1YEAR Months Days Hours Min. 11. IF UNDER 24 HRS.
7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk			10b. KIND OF BUSINESS OR INDUSTRY U.S. Vet. Ad.		
11. BIRTHPLACE (State or foreign country) Maryland			14. MOTHER'S MAIDEN NAME Elsie D. Pickett		
13. FATHER'S NAME Francis Payton Baldwin			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
			16. SOCIAL SECURITY NO. 17. INFORMANT Russell L. Baldwin; same address as # 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiac Asthma (a), stating the underlying cause lost. DUE TO (c) Cardiovascular renal disease			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Bronchial asthma			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>			DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 18, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/59	22c. NAME OF CEMETERY OR CREMATORIAL Savage Cem.	22d. LOCATION (City, town, or county) Savage Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dewitt Danaldson, Laurel Md</i>			ADDRESS <i>Dewitt Danaldson, Laurel Md</i>	24a. REC'D BY REGISTRAR DATE MAY 25 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

卷之三

- 4 -

上級課題の問題を解くには、問題文をよく理解する必要があります。

卷之三

9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05865

1. PLACE OF DEATH a. COUNTY		5869 PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS				
HYATTSVILLE		3 YEARS		HYATTSVILLE		16613 - 23rd Ave.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
6613 - 23rd Ave										
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
MARGARET MARY				BECKER	MAY	15		1959		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	AUG. 24, 1887	71				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Housewife			—			DISTRICT OF COLUMBIA			U.S.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address HYATTSVILLE 6613 - 23rd Ave				
BARTHOLAMEW SUMMERS			ANN GEMENY							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)	INTERVAL BETWEEN ONSET AND DEATH
NO			—			DOLORES PENNINGTON			COPULMONARY edema	5 days
289.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			(b)						Uremia	6 yrs
			(c)						Nephro-calcinosis	6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			None						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)	
19										
21. I certify that I attended the deceased from <u>May 15</u> , 1959, to <u>May 15</u> , 1959, that I last saw the deceased alive on <u>May 15</u> , 1959, and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			DATE SIGNED	
ACTUAL SIGNATURE			M.D.			8641 Colesville Road, Silver Spring, Md				
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)		
Burial		May 18 1959		Mt. Olivet Cem.		Washington		DC		
23. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS			24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
H. Don. DeVol - 2224 - 21st. Ave						DATE MAY 18 '59		Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05866

5879 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 29 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 1108 Queensbury Rd.,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Margaret	Middle M	Last Broderick	4. DATE OF DEATH	Month May	Day 9	Year 1959	
5. SEX	6. COLOR OR RACE Female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-85	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Ansonia, Conn.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Daniel McCarthy		14. MOTHER'S MAIDEN NAME Ellen Garvey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT F.J. Broderick		Address 4108 Queensbury Road Hyattsville, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident - Repeated DUE TO Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH Immediate 3 weeks								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertensive Cardio-Vascular Disease (c) Osteitis, Cystizing, Severe 10-15 yrs 5 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan 1956 , to May 9 1959 , that I last saw the deceased alive on May 9 1959 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 6124 41st Avenue Hyattsville, Md						
ACTUAL SIGNATURE <i>Gordon W Kelley</i>		DATE SIGNED 5/9/59						
PHYSICIAN'S NAME (Type) Dr. Gordon Kelley		6124 41st Avenue Hyattsville, Md						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-11-59		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) Ansonia, Connecticut		
23. FUNERAL DIRECTOR'S SIGNATURE <i>James T. Ryan, Inc.</i>		ADDRESS 317 Penna. Ave., SE DC3		24a. REC'D BY REGISTRAR MAY 12 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Phane</i>		

THE STATE OF DELAWARE - SEASIDE - 19

CERTIFICATE OF DEATH

DEATH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05867

5880

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 40 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS / 6014 Mustang Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Harry	Middle Chase	Lost Brown	4. DATE OF DEATH May	Month May	Day 23	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3 April 1908		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Supervisor		10b. KIND OF BUSINESS OR INDUSTRY D.C.Traffic Dept.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Wilburn Brown		14. MOTHER'S MAIDEN NAME Ida Emily Norris						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT William W. Brown, 3635 Highwood Dr.S.E.Wash.DC		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Pulmonary Infarcts, multiple 2 mos				INTERVAL BETWEEN ONSET AND DEATH 2.4 mos		
Phlebothrombosis multiple						Adenocarcinoma of Pancreas 4 mos.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)		
21. I certify that I attended the deceased from		4/17, 1959, to		5/23, 1959,	that I last saw the deceased			
alive on		5/23, 1959,		and that death occurred at	2,451	A.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		Dr. Norman Comeau, M.D.		3503 Cherry St.		DATE SIGNED 5/23/59		
PHYSICIAN'S NAME (Type)				215 Rainier Rd				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 26th, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cem.	22d. LOCATION (City, town, or county) Arlington, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE W.W.Chambers Company, Riverdale, Md.		ADDRESS	24a. REC'D BY REGISTRAR MAY 26 '59	24b. REGISTRAR'S SIGNATURE John S. Kraus				

REGULAR STATE DEPARTMENT OF HIGHWAY - GAUDIOMETER

220 CERTIFICATE OF DESIGN



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05868

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased last resided before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown Md.		c. LENGTH OF STAY IN 1b 4 1/2 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Georges Co. Wash	
3. NAME OF DECEASED (Type or print) NOLA TRULL BROWN		d. STREET ADDRESS 2214 Chapman Blvd	
4. DATE OF DEATH Month MAY Day 4 Year 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 13, 1884
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	
11. BIRTHPLACE (State or foreign country) ALABAMA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Newt Trull		14. MOTHER'S MAIDEN NAME Cathie Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT SON - RAY B. BROWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO CEREBRAL THROMBOSIS 2 weeks.		INTERVAL BETWEEN ONSET AND DEATH 3 days	
(c) DUE TO GENERALIZED ARTERIOSCLEROSIS 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN , 19 59 , to 4 May , 19 59 , that I last saw the deceased alive on 4 May , 19 59 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G. Maloney		ADDRESS (Street, city or town, state) 4814-71st Ave. Lanark Hills	
PHYSICIAN'S NAME (Type) THOMAS G. MALONEY		DATE SIGNED 4 May 59	
22a. BURIAL/CREMATION, REMOVAL (Specify) 5/5/59 Removal		22b. DATE THEREOF 5/5/59	
22c. NAME OF CEMETERY OR CREMATORIUM Kensington Cem.		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur & Thomas		24a. REC'D BY REGISTRAR DATE MAY 7 '59	
ADDRESS 3732 N.W.		24b. REGISTRAR'S SIGNATURE Arthur & Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05869

5927 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Prince George</i> MARYLAND		<i>Maryland, Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
<i>Gilmount Heights</i>	<i>30 yrs.</i>	<i>Gilmount Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>611-60" Place</i>	<i>1611-60" Place</i>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>George Henry Bush</i>			
4. DATE OF DEATH	Month	Day	Year
<i>May 4</i>			<i>1959</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Male Negro</i>			<i>2-9-1887</i>
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
<i>72</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Laborer</i>	<i>U.S. Govt.</i>	<i>St. Mary's Co., Md.</i>	<i>U.S.A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>John Alfred Bush</i>	<i>Janette Bush</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<i>No</i>	<i>unknown</i>	<i>Montilleita Bush - 611-60" Pl.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>Cerebral Hemorrhage</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<i>Hypertensive Cardio-Vascular Disease, atherosclerosis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
<i>May 4 1959</i>		<i>Not while at work</i>	<i>Baltimore, Md.</i>
21. I certify that I attended the deceased from <i>Sept. 1958</i> to <i>May 4, 1959</i> , that I last saw the deceased alive on <i>May 4, 1959</i> , and that death occurred at <i>845 N. W. 27th St., Washington 27, D.C.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Robinson</i>		ADDRESS (Street, city or town, state) <i>1001 Eastern Ave. N.E., Washington 27, D.C.</i>	
PHYSICIAN'S NAME (Type) <i>John W. ROBINSON, M.D.</i>		DATE SIGNED <i>5/4/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-7-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn</i>
22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marylee K. Collins</i>		ADDRESS <i>4339 Hunt Pl., N.E.</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 6 '59</i>
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
EDMONTE GOURDE	45	M	CHOLERA
ADDRESS	RELATIONSHIP	NAME OF DOCTOR	NAME OF HOSPITAL
10 RUE DES PECHEURS	SPOUSE	DR. J. M. JEAN	HOPITAL DE LA PAIX
PORT-AU-PRINCE	WIFE	DR. J. M. JEAN	HOPITAL DE LA PAIX
HAITI	DEATH DATE	TIME	DEATH TIME
10 NOVEMBER 2010	10:00 PM	10:00 PM	10:00 PM
DEATH PLACE	NAME OF FUNERAL DIRECTOR	NAME OF CEMETERY	
HOSPITAL DE LA PAIX	DR. J. M. JEAN	CEMETEY DE LA PAIX	
REMARKS	INITIALS	INITIALS	INITIALS
EDMONTE GOURDE	JM	JM	JM

DEPARTMENT OF STATE DEVELOPMENT GOVERNMENT OF HAITI - PORT-AU-PRINCE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05870

5928 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md		b. COUNTY		Pr. George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x Rural Laurel		d. STREET ADDRESS			
Rural Laurel		2 yrs									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year			
Mary Frances Campbell					May	29	1959				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years, lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
F	nl			July 31, 1892	66 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife		Home		Virginia		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Charles Pines		Lydia M. Sheets									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no				Jessie L Campbell, Laurel Md							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS											
420.1 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) CORONARY ATHEROSCLEROSIS											
DUE TO											
(c)											
INTERVAL BETWEEN ONSET AND DEATH 10 yrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that I attended the deceased from 5-27, 1957, to 5-29, 1959, that I last saw the deceased alive on 5-27, 1959, and that death occurred at 10 AM, from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) 320 Montgomery ACTUAL SIGNATURE M.D. DATE SIGNED F. L. Weaver											
PHYSICIAN'S NAME (Type) F. L. WEAVER LAUREL, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)			
Burial		6/1/59		Thorn Rose Cem.		Staunton Va.					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Rekitt Pendleton, Laurel Md				DATE JUN 3 '59		Caroline S. Turner					

WILLIAM STATE DEPARTMENT OF HEALTH - DIVISION 18

0524 - CERTIFICATE OF DEATH

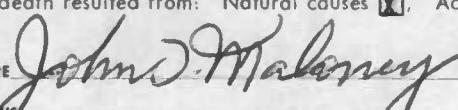
16

**FOR STATE
HEALTH DEPT.**

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 05871					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND												2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale Woods- Riverdale					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital												d. STREET ADDRESS 6015 Mustang Court					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Middle Last						4. DATE OF DEATH			Month			Day		Year			
Bernard Dominic Carroll. Jr.						May 7, 1959											
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.					
Male		white		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		October 23, 1912		46 yrs.		Months		Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician						10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't						11. BIRTHPLACE (State or foreign country) Washington, D.C.					
13. FATHER'S NAME Bernard Dominic Carroll, Sr.						14. MOTHER'S MAIDEN NAME Dora Roth						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, W.W.2. (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Melvin F. Carroll; 9401 Washington Blvd. Lanham, Maryland Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Acute congestive heart failure																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cardiovascular renal disease																	
(c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Hypertension																	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
 ACTUAL SIGNATURE John T. Maloney, M.D. EXAMINER'S NAME (Type)												M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 7, 1959					
22a. BURIAL, CREMATION, BURIAL (Specify)		22b. DATE THEREOF 5/11/59		22c. NAME OF CEMETERY OR CREMATORIALY Arlington National		22d. LOCATION (City, town, or county) Arlington		(State) Va.									
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons						4739 Baltimore Ave, Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 11 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kraus							

18280
WISCONSIN STATE DEPARTMENT OF HEALTH - MEDICAL EXAMINERS OFFICE

FOR STATE
WISCONSIN

Medical Record No.

Date of Birth

Date of Death

Sex

Age

Color

Height

Weight

Occupation

Employer

Address

City

State

Country

Marital Status

Religious Preference

Education

Employment

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05872

CERTIFICATE OF DEATH

Reg. Dist. No.

5882

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3601-Taylor St.		d. STREET ADDRESS 13601-Taylor St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ralph	Middle Earl	Last Collins.			
4. DATE OF DEATH	Month May	Day 19	Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Miller Station Penna.		
13. FATHER'S NAME Francis Collins		14. MOTHER'S MAIDEN NAME Mary Houghton		12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 190-2-1908		17. INFORMANT Address Ralph E. Collins, Jr.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.0 DUE TO coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 2 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease Years. (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 8, 1959, to May 19, 1959, that I last saw the deceased alive on May 9, 1959, and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William H. Clements M.D. M.D. 6001-35th Ave Hyattsville 5/1959						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 5/21/59		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		ADDRESS Mr. Rainier		24a. REC'D BY REGISTRAR DATE MAY 22 '59		
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

DEPARTMENT OF MOTOR VEHICLES
STATE GOVERNMENT OF NEVADA - DIVISION OF

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05873

5883 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE		c. LENGTH OF STAY IN 1b 2 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6311-59 th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THULIA		First	Middle
		LAST	COLLINS
4. DATE OF DEATH		Month	Day
		MAY	16
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH MAR 24, 1891	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. SOCIAL SECURITY NO. None		16. INFORMANT ETHEL OTTEY Address 6311-59 AVE RIVERDALE	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		18. INTERVAL BETWEEN ONSET AND DEATH 9 HOURS CORONARY THROMBOSIS	
19. MEDICAL CERTIFICATION		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1, 1959, to MAY 16, 1959, that I last saw the deceased alive on MAY 16, 1959, and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE SAMUEL J. N. SUGAR M.D.		ADDRESS (Street, city or town, state) 4300 KAYWOOD DRIVE, MD. DATE SIGNED 5/16/59	
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR M.D. MT RAINIER, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/1959	
22c. NAME OF CEMETERY OR CREMATORIAL NEW HAVEN CH. CH.		22d. LOCATION (City, town, or county) GORDON, TW 1665 Co. Georgia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO - RIVERDALE, MD.		24a. REC'D BY REGISTRAR DATE MAY 19 '59	
		24b. REGISTRAR'S SIGNATURE Arthur & Kraus	

CERTIFICATE OF DEATH

Date of Birth

Place of Birth

Cause of Death

Name of Physician

Name of Hospital

Name of Doctor

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5866

CERTIFICATE OF DEATH

05874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Bro Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park Md</i>		c. LENGTH OF STAY IN lb <i>30 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4571 - Knox Rd -</i>		e. STREET ADDRESS <i>14511 - Knox Rd -</i>	
3. NAME OF DECEASED (Type or print) <i>HAROLD F COTTERMAN</i>		4. DATE OF DEATH <i>May 2, 1959</i>	Month Day Year
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 22, 1887</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stringing telephone wires U. of Md</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Ohio</i>
13. FATHER'S NAME <i>Marcus Ward Cotterman</i>		14. MOTHER'S MAIDEN NAME <i>Martha Brubaker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Maie Yingling Cotterman</i> Address <i>College Park Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary Occlusion</i> DUE TO <i>420.1</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Coronary artery disease</i> DUE TO (c) <i>Advanced arteriosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/13, 1949</i> , to <i>5/2, 1959</i> , that I last saw the deceased alive on <i>5/1, 1959</i> , and that death occurred at <i>7:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. Louis Menzel M.D.</i>		ADDRESS (Street, city or town, state) <i>4506 COLLEGE AVE 5/2/59</i> DATE SIGNED <i>5/2/59</i>	
PHYSICIAN'S NAME (Type) <i>C. LOUIS MENDEL</i>		22d. LOCATION (City, town or county) <i>Colmar Manor, Md</i> (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 5/4/59</i>		22b. DATE THEREOF <i>5/4/59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln</i>		22d. LOCATION (City, town or county) <i>Colmar Manor, Md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gusciora Sons Hyattsville Md</i>		24a. REC'D BY REGISTRAR DATE MAY 6 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur & Anna</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05875

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Dist. of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Glenn Dale 10 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Washington 47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hosp.				d. STREET ADDRESS !! 611 U" St N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
CLARENCE				O. CRAWFORD	5/23	5/23	19	59
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/12/12		9. AGE (In years lost birthday) yrs. 46	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY restaurant		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME John Crawford		14. MOTHER'S MAIDEN NAME Sallie Bradshaw						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 243-22-3452		17. INFORMANT Deceased		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X PULMONARY FIBROSIS, GENERALIZED, DUE TO ETIOLOGY UNDETERMINED						INTERVAL BETWEEN ONSET AND DEATH 3 YRS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)						
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
COR PULMONALE BULLOUS EMPHYSEMA								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from alive on _____		7/31, 1958, to 5/23, 1959, and that death occurred at 8 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE Moe Weiss M.D.		M.D.		Glenn Dale Hosp.		DATE SIGNED 5/24/59		
PHYSICIAN'S NAME (Type)				Glenn Dale, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/24/59		22c. NAME OF CEMETERY OR CREMATORIAL 5-29-59, Woodlawn Cem.		22d. LOCATION (City, town, or county) Washington, D. C. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Hall Bros		24a. ADDRESS M. D. 621 Fl. Ave, 72115		24a. REC'D BY REGISTRAR DATE MAY 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

VERMONT STATE DEPARTMENT OF HEALTH - ALTIMORE

559 - CERTIFICATE OF DEATH

DEATH

85.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5884

CERTIFICATE OF DEATH

Reg. Dist. No.

05876

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 hr		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Davis	
4. DATE OF DEATH	Month 8	Day May	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 May 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Yes		
13. FATHER'S NAME Clyde R Davis		14. MOTHER'S MAIDEN NAME Mabel Pendleton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mother		
18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Deletum Prematurity		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day 2	Year 1959	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5301 Hamilton Rd., Hyattsville	20f. (City or town) Hyattsville	(County) Md.	(State) Md.
21. I certify that I attended the deceased from May 8, 1959 , to May 8, 1959 , that I last saw the deceased alive on May 2, 1959 , and that death occurred at 5, 15 A.M. , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>John W. Perkins</i>	ADDRESS (Street, city or town, state) 5301 Hamilton Rd., Hyattsville			DATE SIGNED May 8, 1959
PHYSICIAN'S NAME (Type) Dr. John Perkins M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 6/5/59	22c. NAME OF CEMETERY OR CREMATORIAL Prince George's General Hospital, Cheverly, Md.	22d. LOCATION (City, town, or county) Cheverly, Md.	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry W. Penn, Jr.</i>	ADDRESS Administrator	24a. REC'D BY REGISTRAR Arthur S. Kraus	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	DATE JUN 8 '59

MISSOURI STATE DEPARTMENT OF HIGHWAYS AND TRANSPORTATION

6894

CERTIFICATE OF DATA



MISSOURI STATE DEPARTMENT OF HIGHWAYS AND TRANSPORTATION

6894 CERTIFICATE OF DATA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5885

Item 9 Film G243 5/28/59 cap

CERTIFICATE OF DEATH

Reg. Dist. No.

05877

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 106 Dr. St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Edmondz	Middle Deal	Last	4. DATE OF DEATH	Month May	Day 23	Year 1959
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4 Dec. 1889	9. AGE (In years last birthday) 68 9 yrs.	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 9	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASBESTOS WORKER		10b. KIND OF BUSINESS OR INDUSTRY ASBESTOS		11. BIRTHPLACE (State or foreign country) FT. SILL OKLAHOMA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM HARVEY DEAL		14. MOTHER'S MAIDEN NAME EMMA MARGARET WILLIAMS		Address 4700 NAVHO ST. COLLEGE PARK, MD.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 094-03-7107		17. INFORMANT MRS. NAOMI C. DEAL		INTERVAL BETWEEN ONSET AND DEATH 5 days.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Pneumonia		Myocardial infarction		7 days.	
		Arteriosclerotic heart disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year May 16, 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 524187 Barneslas R.R. # 5/23/59	20f. (City or town) May 23, 1959	(County) 1959	(State) MD	
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 524187 Barneslas R.R. # 5/23/59		DATE SIGNED 5/23/59	
ACTUAL SIGNATURE John T. Lynn, M.D.							
PHYSICIAN'S NAME (Type) Dr. John T. Lynn, M.D.							
22a. BURIAL, CREMATION, REMOVAL FROM STATE Mt. Holly Springs 5/26/59	22b. DATE THEREOF 5/26/59	22c. NAME OF CEMETERY OR CREMATORIAL MT. HOLLY SPRINGS	22d. LOCATION (City, town, or county) PA, CUMB.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasche Sons Hyattsville Md	ADDRESS	24a. REC'D BY REGISTRAR MAY 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5930 CERTIFICATE OF DEATH

Reg. Dist. No.

05878

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George's Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Pr. Geo's Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Seat Pleasant, Maryland					
d. NAME OF HOSPITAL (If not in hospital, give street address) 6216- Brooks Road S.E.				d. STREET ADDRESS 6216- Brooks Road S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First ANN	Middle DENNISON	Last 	4. DATE OF DEATH May 19th.	Month May	Day 19	Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 28- 1872		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John T. Gibson		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Raymond B. Dennison		Address Same as # 2. (Son)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure INTERVAL BETWEEN ONSET AND DEATH 3 days									
447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Hypertensive Arteriosclerosis 12 years.									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 19 DEC. 1948 to 19 MAY, 1959 , that I last saw the deceased alive on 19 MAY, 1959 , and that death occurred at 4:59 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 7200-MARLBORO PIKE SE. 28DC. DATE SIGNED Sidney W. Lowry									
ACTUAL SIGNATURE Sidney W. Lowry		M.D. 7200-MARLBORO PIKE SE. 28DC.							
PHYSICIAN'S NAME (Type) SIDNEY W. LOWRY MD DISTRICT HEIGHTS, MD.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 21-59		22b. DATE THEREOF 1661- Good Hope Rd. S. E.		22c. NAME OF CEMETERY OR CREMATORIAL Washington National Cemetery		22d. LOCATION (City, town, or county) Southeast End. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Linnmore Bros.		1661- ADDRESS Washington, 20, D.C. S. E.		24a. REC'D BY REGISTRAR Arthur & Kraus		24b. REGISTRAR'S SIGNATURE Arthur & Kraus			
VS A15 (4) 15M 9/58		DATE MAY 20 '59							

STANFORD UNIVERSITY LIBRARIES

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Bullock, Franklin

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Letters, 1850-1852, 1850-1852

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05879

Reg. Dist. No.

5886

1. PLACE OF DEATH
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb
32 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Edward

Donaldson

4. DATE
OF
DEATH
May 22

Month
May

Day
22

Year
19 59

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 21

9. AGE (In years
last birthday)
88 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.
12 months 0 days 0 hours 0 min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Insurance Broker

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME

Noah Donaldson

14. MOTHER'S MAIDEN NAME

Antoinette Ijams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Thelma Brunella

Address

Address Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Bronchopneumonia

INTERVAL BETWEEN
ONSET AND DEATH

904.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

DUE TO

(c)

Fracture to the left Femur

2 MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fall in home

20c. TIME OF INJURY
Hour 10
p. m. 4/20 1959

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
Home

20f. (City or town)
Hyattsville

(County)

(State)

Maryland

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

John J. Maloney

DATE SIGNED

EXAMINER'S
NAME (Type)
Dr. J. Maloney M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

5/22/59

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

May 25, 1959

22c. NAME OF CEMETERY OR CREMATORIUM

St Stephen Cem.

22d. LOCATION (City, town, or county)

Braddock, Md

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Rev W. Donaldson, Laurel Md

24a. REC'D BY REGISTRAR

MAY 26 '59

DATE

24b. REGISTRAR'S SIGNATURE

Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
BM 2/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5887

CERTIFICATE OF DEATH

05880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hastwood		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince georges General						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Aneita	Middle Dotson	Last 	4. DATE OF DEATH May 0 1959	Month May	Day 0	Year 1959
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 26 1890	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME 		14. MOTHER'S MAIDEN NAME 					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Elizabeth Middletons Westwood md		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia arteriosclerotic heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CVA - thrombosis ; Decubitus ulcer DUE TO (c).							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) 	(County) 	(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 9:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Till Bergemann				ADDRESS (Street, city or town, state) 4314 fallston st.			
PHYSICIAN'S NAME (Type) Dr. Till Bergemann				DATE SIGNED May 12 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/13/59	22c. NAME OF CEMETERY OR CREMATORIUM Brooks M. church Prince George Md	22d. LOCATION (City, town, or county) Co. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE George L. Lessen Aguascome		ADDRESS Liquors come	24a. REC'D BY REGISTRAR MAY 12 '59	24b. REGISTRAR'S SIGNATURE Arthur & Thora			

WISCONSIN STATE DEPARTMENT OF HEALTH - MEDICAL RECORDS
CERTIFICATE OF DEATH

C DC 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5931 CERTIFICATE OF DEATH

05881

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Prince Georges</i> MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale Md		c. LENGTH OF STAY IN 1b 22 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale Md		d. STREET ADDRESS 1 Glendale Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glendale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Mary</i>	Middle <i>Margret</i>
		Last <i>Daley</i>	4. DATE OF DEATH May 20 1959
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 6 1881</i>
9. AGE (In years last birthday) yrs. <i>77</i>	10. UNDER 1 YEAR Months <i>0</i>	11. UNDER 24 HRS. Days <i>0</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Houswife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	13. FATHER'S NAME <i>John H. B. Swain</i>
14. MOTHER'S MARRIED NAME <i>Marta Rawlings</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, rank, war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs Lucy Wiser Lantam Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Cerebral Vascular Thrombosis (Stroke) last 6 days</i>			
DUE TO (c) <i>Cerebral Vascular Arterosclerosis Years</i>			
generalized Arterosclerosis Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hypertensive Arterosclerotic Heart Disease, Malnutrition</i>			
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19	19		
21. I certify that I attended the deceased from <i>Aug</i> , 1952 to <i>May 20</i> , 1959, that I last saw the deceased alive on <i>5/19</i> , 1959, and that death occurred at <i>5/20</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. James Kirtz</i>	M.D.	R.F.D. <i>Bowie Md</i>	DATE SIGNED <i>5/20/59</i>
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
<i>H. James Kirtz</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 23-1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Busche sons Hyattsville Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 22 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

5888

05882

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5873 CERTIFICATE OF DEATH

Reg. Dist. No.

05883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		Princ Georges							
Mt. Rainier													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		3511-37th street		d. STREET ADDRESS		13511-37th street							
Rhoda S.		First Middle Last		4. DATE OF DEATH		Month	Day	Year					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9/5/1870		Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		Elgin, Ill.		12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
Housewife		own home											
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Oliver O. Sabine		unknown											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
(If yes, give war or dates of service)								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Hypostatic pneumonia (terminal)			
422.1								DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Chronic myocarditis				(c)		Cerebral Arterio-Sclerosis - Senility			
DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from May 13, 1959, to May 21, 1959, that I last saw the deceased alive on May 21, 1959, and that death occurred at 9P.M., from the causes and on the date stated above.													
ACTUAL SIGNATURE William Henry		M.D.											
PHYSICIAN'S NAME (Type)		William J. Kure MD		6409 COLESVILLE ROAD HEIGHTS									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)					
Burial		5/23/59		Fort Lincoln		Colmar Manor, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Halley's Funeral Home Inc.		Mt. Rainier Md.		DATE MAY 25 '59		Arthur S. Kraus							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05884

5932 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Prince George</i> MARYLAND		b. COUNTY 47x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Cedar Hts.</i>	<i>3 weeks</i>	<i>Washington, D. C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
<i>6209 L St.</i>	<i>2124 North Capitol St.</i>		
3. NAME OF DECEASED (Type or print)	First <i>Virginia</i>	Middle <i>Ellen</i>	Last <i>Edler</i>
4. DATE OF DEATH	Month May	Day 20	Year 1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 6, 1875</i>
9. AGE (In years lost birthday) 83 yrs	10. IF UNDER 1 YEAR Months 18	11. IF UNDER 24 HRS. Days 18	12. IF UNDER 24 HRS. Hours 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Samuel</i>	14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Lloyd F. Robinson - 6207-L St.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
Cerebral Cardio-Vascular Disease			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Natural Conditions of Age</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3-13-59</i> , to <i>5-20-59</i> , that I last saw the deceased alive on <i>3-19-</i> , 19 <i>59</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>John W. Robinson, M.D., 1001 Eastern Ave. N.E.</i>	
ACTUAL SIGNATURE <i>John W. Robinson, M.D.</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>John W. Robinson, M.D., Washington 27, D.C.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5-24-59	22c. NAME OF CEMETERY OR CREMATORIAL Local	22d. LOCATION (City, town, or county) 5357 Sylvanis, VA.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. ERNEST JARVIS Jr.</i>		ADDRESS <i>1432 Yon St. N.W.</i>	24a. REC'D BY REGISTRAR DATE MAY 25 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05885

Reg. Dist. No.

5889 CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 117 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		d. STREET ADDRESS 6111 Arbor St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Lucile	Middle Armstrong	Last Elkins	4. DATE OF DEATH May 7 1959	Month May	Day 7	Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 21 Dec. 1904	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Record Librarian		10b. KIND OF BUSINESS OR INDUSTRY D.C. Hosp.		11. BIRTHPLACE (State or foreign country) Dana, Iowa		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George A. Armstrong		14. MOTHER'S MAIDEN NAME Jessie Davis						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles M. Elkins, 6111 Arbor St., Cheverly, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o.) 157X		<i>Intestinal obstruction</i>				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (o.), stating the under- lying cause first. (b)		<i>Adeno carcinoma of the head of pancreas.</i>						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Colmar Manor	(County) Pr. Geo. Co., Md.	(State) Md.
21. I certify that I attended the deceased from Jan 1, 1959 to May 7, 1959 , that I last saw the deceased alive on May 6, 1959 , and that death occurred at 6:15 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE George H. McLain		ADDRESS (Street, city or town, state) 1746 K St. NW - Wash - 6 - D.C.						DATE SIGNED
PHYSICIAN'S NAME (Type) Dr. George McLain, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Pr. Geo. Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers Co		ADDRESS 5851 CLEVELAND AVE RIVERDALE MD		24a. REC'D BY REGISTRAR DATE MAY 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

MANUFACTURER STATE ORIGINATOR - CALIFORNIA

CERTIFICATE OF DEATH

DEATH

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5890

CERTIFICATE OF DEATH

05886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Colmar Manor			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 4010 Lawrence St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Russell	Middle Franklin	Last Estep	4. DATE OF DEATH May 25 1959	Month May	Day 25	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19 1910	9. AGE (In years lost birthday) 49 yrs.	10. IF UNDER 1 YEAR Months 0	Days 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintainance Work		10b. KIND OF BUSINESS OR INDUSTRY Laundry , Industrial		11. BIRTHPLACE (State or foreign country) Macanie, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Ashby Estep				14. MOTHER'S MAIDEN NAME Lillie Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Helen L. Estep, 4010 Lawrence St.		Address Colmar Manor, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Purulent Pericarditis DUE TO (c) Gastric encephalitis acute							
INTERVAL BETWEEN ONSET AND DEATH 5-16-59							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-11 1959 to 5-25 1959 , that I last saw the deceased alive on 5-25-1959 , and that death occurred at 6:00 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) George J. Hageage M.D. 3711-38 fl ee College City							
ACTUAL SIGNATURE George J. Hageage							
DATE SIGNED 5/25/59							
PHYSICIAN'S NAME (Type) Dr. George Hageage		22d. LOCATION (City, town, or county) Macanie, Virginia					
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF May 29th, 1959		22g. NAME OF CEMETERY OR CREMATORIUM Mt. Hermon Church Cemetery		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Krause	

MANUFACTURED BY THE DEPARTMENT OF DEFENSE - CALIFORNIA
6880 CERTIFICATE OF DESIGN

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Lancaster	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Route # 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ENOS	First	Middle KLINE	Last FREY
4. DATE OF DEATH May 26th, 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22nd, 1886
			9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Lancaster Co., Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Frey		14. MOTHER'S MAIDEN NAME Fannie Kline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Clara B. Frey, Route # 1, Millersville, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Cardio-vascular renal disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED	
EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29th, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Millersville Mennonite Cem.		22d. LOCATION (City, town, or county) Millersville, Lancaster Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE MAY 28 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Knapp	

114018

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05888

5892

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Carmody Hills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 1307--74th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARTHA	Middle ANN	Last PATTIE	4. DATE OF DEATH FROST	Month May	Day 7th,	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10th, 1870	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Grayson County, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willis Melton				14. MOTHER'S MAIDEN NAME Minerva Leonard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hattie E. Stoneman, 307--74th Pl. Carmody Hills, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) EMPYEMA & BRONCHOPNEUMONIA RIGID 6 WEEKS DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE ? YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 MAY</u> , 1959, to <u>7 MAY</u> , 1959, that I last saw the deceased alive on <u>6 MAY</u> , 1959, and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE <u>Henry R. Wolfe</u> M.D. 905 Sheridan Street, PHYSICIAN'S NAME (Type) Henry R. Wolfe Chillum Terrace, Hyattsville P.O., Md.							
DATE SIGNED <u>5/9/1959</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/12/1959		22c. NAME OF CEMETERY OR CREMATORIUM Ballard Cemetery		22d. LOCATION (City, town, or county) Galax, Grayson County, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 12 '59	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05889

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN Tb 4 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville (Chillum)		d. STREET ADDRESS 806 Berkshire Dr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Gill	4. DATE OF DEATH May 6 1959	Month May	Day 7	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6 May 1959	9. AGE (In years lost birthday) yrs. 4	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 4	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Jean Gill					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prematurity							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hyattsville	(County) Md.	(State) Md.
21. I certify that I attended the deceased from May 6, 1959 to May 7, 1959 , that I last saw the deceased alive on May 7, 1959 , and that death occurred at 1:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John. Perkins.</i>	ADDRESS (Street, city or town, state) 5301 Hanover St., Hyattsville, Md.						DATE SIGNED 5/9/59
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 6/5/59	22c. NAME OF CEMETERY OR CREMATORIAL Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Penn Jr.</i>		ADDRESS Administrator.	24a. REC'D BY REGISTRAR DATE JUN 8 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5894

CERTIFICATE OF DEATH

Reg. Dist. No.

05890

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.		c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lanham			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		d. STREET ADDRESS 9200 Defense Highway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Howard	Middle Vernon	Lost Goding	4. DATE OF DEATH May	Month 19	Day 19	Year 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-92	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months Hours	IF UNDER 24 HRS. Days Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Retired		10b. KIND OF BUSINESS OR INDUSTRY Real Estate - Md.		11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Franklin Goding			14. MOTHER'S MAIDEN NAME Winifred Orne				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Wife -9200 Defense Highway Lanham, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate							
INTERVAL BETWEEN ONSET AND DEATH Sudden death							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Carcinoma of Prostate					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Suitland, Md.	(County) Calvert Co.	(State) Md.
21. I certify that I attended the deceased from May 5, 1959, to May 19, 1959, that I last saw the deceased alive on May 19, 1959, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riverside, Md.							
DATE SIGNED L.W. Malin 5-20-59							
ACTUAL SIGNATURE L.W. Malin							
PHYSICIAN'S NAME (Type) Dr. L.W. Malin							
22a. BURIAL, CREMATION, BURIAL <input type="checkbox"/>	22b. DATE THEREOF May 22, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Suitland, Md.		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Harbin's Sons		24a. REC'D BY REGISTRAR MAY 22 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline				
		DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burier-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		5895 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		d. STREET ADDRESS Guilford Rd	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Baby	Middle Girl	Last Gosnell	4. DATE OF DEATH	Month May	Day 23	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 21 May 1959	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 2	Hours 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) name		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Grady Wayne Gosnell		14. MOTHER'S MAIDEN NAME Mary Frances Gibson		<i>Grady W. Gosnell, Jessups Md</i> Address Cerebral hemorrhage, petechial 1 day INTERVAL BETWEEN ONSET AND DEATH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/21 , 19 59 , to 5/23 , 19 59 , that I last saw the deceased alive on 5/23 , 19 59 , and that death occurred at 6,20A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 402 Main St Laurel Md DATE SIGNED 5/23/59							
ACTUAL SIGNATURE <i>J.R. Buell</i>		M.D.					
PHYSICIAN'S NAME (Type) Dr. J.R. Buell, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/24/59		22c. NAME OF CEMETERY OR CREMATORIUM Harrison Cemetery		22d. LOCATION (City, town, or county) (State) Harrison Co. Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>We Witt Funeral Home Laurel Md</i>		ADDRESS 2077201 X V5		24a. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATE OF TEXAS
DEPARTMENT OF STATE

CHARTER OF STATE

RECORDED IN THE

CLERK'S OFFICE

ON THE DAY OF JUNE, 1856.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05892

CERTIFICATE OF DEATH

Reg. Dist. No.

5896

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). Cheverly		c. LENGTH OF STAY IN 1b 1 Mo. 15 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. STREET ADDRESS 14510 Anmert Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Ethel	Middle Arlington	Last Green	4. DATE OF DEATH May 4 1959	Month May	Day 4	Year 1959			
5. SEX Female	6. COLOR OF RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 24 1893	9. AGE (In years and birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Retail store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME George L. Arlington		14. MOTHER'S MAIDEN NAME Adelaide Brathingson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-05-9655				
17. INFORMANT Mrs J.R. Brathingson		Address 4810 Anlonyty, Mrs J.R. Brathingson College Park, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 34 hrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		Broncho pneumonia, below		Carcinoma of the vagina.		5 mo. Jan 9-1959				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) College Park, Md	20f. (City or town) College Park	(County) Montgomery Co	(State) Md
21. I certify that I attended the deceased from 2-14 , 19 49 , to May 4 , 19 59 , that I last saw the deceased alive on May 3 , 19 59 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4506 COLLEGE AVE		ACTUAL SIGNATURE C. Louis Mendel		DATE SIGNED 5/4/59				
PHYSICIAN'S NAME (Type) C. LOUIS MENDEL		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/59	22c. NAME OF CEMETERY OR CREMATORIAL Sky Hill Cemetery Laurel, Md	22d. LOCATION (City, town, or county) Laurel, Md	(State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Randolph Laurel, Md		ADDRESS 14510 Anmert Road		24a. REC'D BY REGISTRAR May 8 '59	24b. REGISTRAR'S SIGNATURE Clairton S. Johnson					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SI VASCUA EST JACINTO TOLVANHO STATE CHAUKAM.

ESTATE DE STADTREIC

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your office.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

5933

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Clinton		a. STATE Maryland b. COUNTY Prince Geo.
c. LENGTH OF STAY IN 1b	43 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Temple Hill Road		X Clinton

3. NAME OF DECEASED (Type or print)	First George	Middle Allen	Last Green	4. DATE OF DEATH	Month May	Day 24	Year 19 59
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5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1YEAR	IF UNDER 24 HRS.
Male	Colored	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 1891	68 yrs.	Months Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Farm	Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
John E. Green	Annie Maria Hawkins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no		Claude Green, Clinton, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
442X	DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)
	DUE TO
	(c)
Acute congestive heart failure	
Cardiovascular renal disease	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)	19. WAS AUTOPSY PERFORMED?
	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>
--

ACTUAL SIGNATURE <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED May 24, 1959
EXAMINER'S NAME (Type) James I. Boyd		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-28-59	22c. NAME OF CEMETERY OR CREMATORIUM Gibson Church	22d. LOCATION (City, town, or county) Brandywine Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Myrtle R. Bolling</i>	ADDRESS 4339 Hunt Pl. N.E.	24a. REC'D BY REGISTRAR DATE MAY 28 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

604-00
01-75000 STATE OF ALASKA - 1981
MEDICAL EXAMINER'S OFFICE

STATE OF
ALASKA

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05894

5897 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 Hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly		d. STREET ADDRESS 3112 Bellview Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Joseph	Middle B	Lost Hardesty	4. DATE OF DEATH May	Month 5	Doy 19	Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 22, 1898	9. AGE (In years 60 birthday) yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Allen B. Hardesty			14. MOTHER'S MAIDEN NAME Anna Sweeney					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Beatrice N. Hardesty		Address Same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Myocardial infarct old. with fibrosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Is the IV sept. involving the regn of the bundle of His. & a cardiac arrhythmia (c) left ventr. due to Arterioscl. of the heart								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) Arlington	(County) Arlington	(State) Va.	
21. I certify that I attended the deceased from 2-2 , 19 44 , to 5-1 , 19 59 , that I last saw the deceased alive on 1959 , and that death occurred at 8:25 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Dr Aaron Dietz	PHYSICIAN'S NAME (Type)		M.D.		ADDRESS (Street, city or town, state) Hoffstede 2-308			
22a. BURIAL, CREMATION, BURNT (Specify) BURNT	22b. DATE THEREOF 5/8/59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington		(State) Va.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			4739 Baltimore Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 7 '59	24b. REGISTRAR'S SIGNATURE Arthur & Frank		

•CV - L. S. C. -
• C V B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05895

5934 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN lb 3 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 7257 - "M" St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First INDIANA	Middle	Last HARRIS	4. DATE OF DEATH Month May	Day 1st	Year 19 59
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 24, 1897	9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Hooks				14. MOTHER'S MAIDEN NAME Maria Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Charles Spears (Son)		Address 7257 M St. N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. LEFT & RIGHT HEART FAILURE.							
(b) CONGESTIVE HEART DISEASE.							
(c) HYPERTENSIVE CARDIO VASCULAR DISEASE							
INTERVAL BETWEEN ONSET AND DEATH 2 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC 5 1955 to MAY 1 1959 , that I last saw the deceased alive on APRIL 30 1959 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 2001 BENNING RD NE							
DATE SIGNED Hugh Browne M.D.							
ACTUAL SIGNATURE Hugh Browne							
PHYSICIAN'S NAME (Type) HUGH BROWNE							
22a. BURIAL, CREMATION, REMOVAL (Specify) May 5, 1959		22b. DATE THEREOF May 5, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ora J. Allen				ADDRESS Wm. D. C. For Brooks & Allen - 1200 Fla. Ave. N.W.		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
						24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5898 CERTIFICATE OF DEATH

05896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Washington 23				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 14401 Branch Ave., S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Carrie	Middle	Last Hickman	4. DATE OF DEATH	Month May	Day 25	Year 19 59	
S. SEX Female	6. COLOR OR RACE Colored	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 21, 1879	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country)* Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Millard				14. MOTHER'S MAIDEN NAME Mary (Maiden Name Unknown) Millard				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Clarence Hickman		Address 4401 Branch Ave., S. E.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
Hour a. m. p. m.	19	While of work <input type="checkbox"/> at work <input type="checkbox"/>						
21. I certify that I attended the deceased from May 23 , 19 59, to May 25 , 19 59, that I last saw the deceased alive on May 25 , 19 59, and that death occurred at 1:45 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE James E. Passer M.D.				ADDRESS (Street, city or town, state) Upper Marlboro				
PHYSICIAN'S NAME (Type) James E. Passer M.D.				DATE SIGNED MP				
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 29, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery	22d. LOCATION (City, town, or county) Washington, D. C.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.		ADDRESS 3015 12th St., N. E.	24a. REC'D. BY REGISTRAR MAY 28 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Krause				
			DATE MAY 28 '59					

U.S. GOVERNMENT PRINTING OFFICE 1913
25-1250-C
U.S. GOVERNMENT DEPARTMENT OF JUSTICE - SALVATION

CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

FOR STATE
HEALTH DEPT.



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ARMED FORCES
MEDICAL ENGINERS CLASSIFICATION

DATA FORM
CLASSIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G243 5/27/59 cap

05898

5935

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		DC		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
D.C.—Adelphi		40 hrs		WASHINGTON		47x-3		
d. NAME OF HOSPITAL (If not in Capital, give street address) OR INSTITUTION		Point French Nursing Home 7526-1251 NW		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Female		white		(none) Hyman	May	16	1959	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
				Mar. 12, 1885				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife				Russia		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Joseph Sandler		UNKNOWN						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no		none		Nursing Home records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		PNEUMONIA				1 WEEK		
162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) BRONCHIOGENIC CARCINOMA WITH METASTASES				3 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from Sept. 30, 1958, to May 16, 1959, that I last saw the deceased alive on May 14, 1959, and that death occurred at 11:44 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE		Robert L. Krichmar		M.D.		7733 ALASKA AVE NW 5/16/59		
PHYSICIAN'S NAME (Type)		ROBERT L. KRICHMAR				WASH 12 DC		
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)
5-18-59						ATLANTIC-		N.J.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS 3501-14 ST NW		REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
B. DANZANSKY & SONS		WASH-D.C.		DATE MAY 20 1959		Arthur & Anna		

1 F9

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

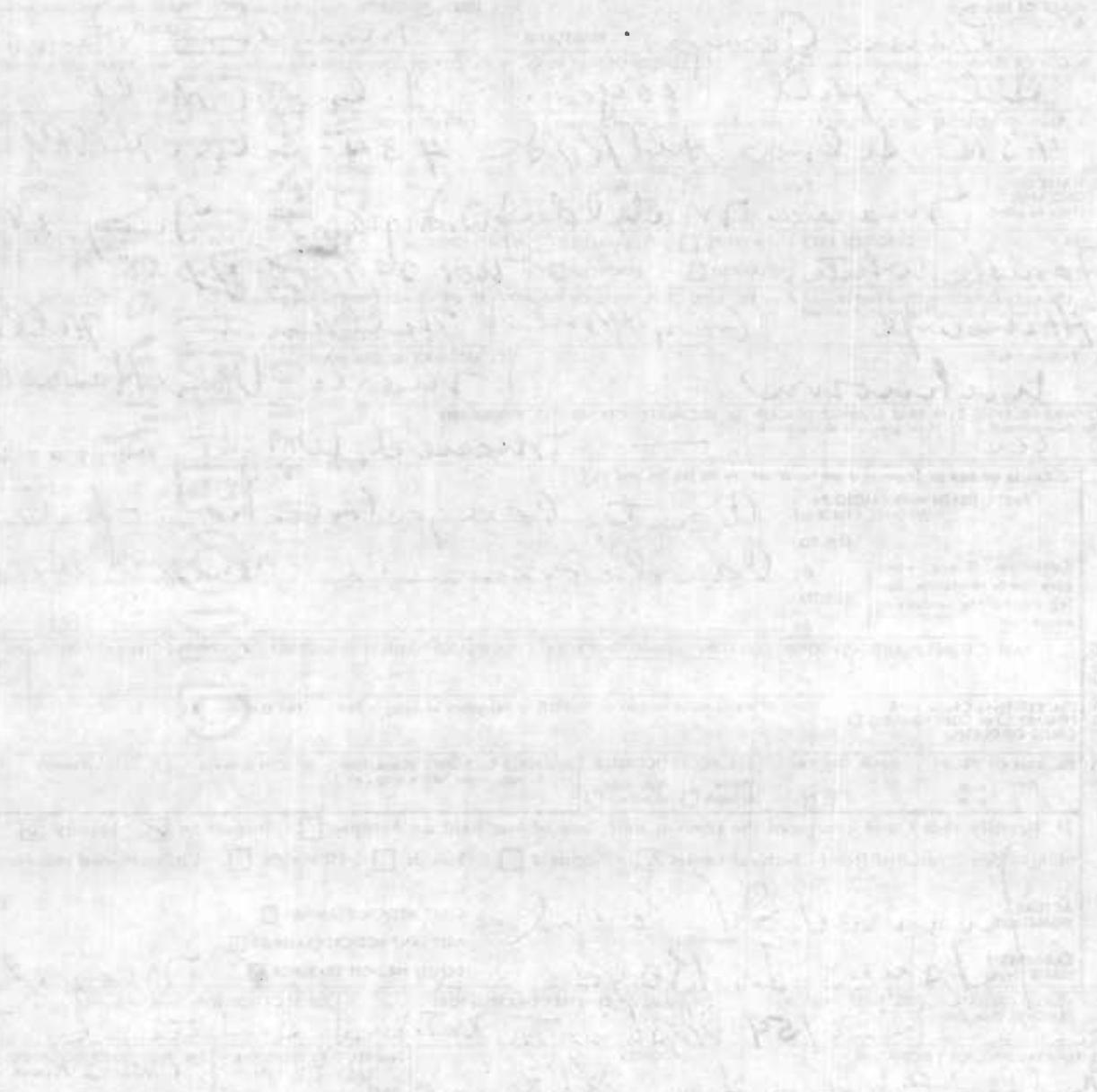
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Item 8 Film 6243 6-2-59 et

05899

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)																	
a. COUNTY		b. STATE <u>Maryland</u> COUNTY <u>Prince George's</u>																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)																	
<u>Silver Hill</u>		<u>Silver Hill</u>																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>4315- Silver Hill Rd</u>																	
4315- Silver Hill Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)		First <u>Maria</u>		Middle <u>Matilda</u>		Last <u>W. Ingram</u>		4. DATE OF DEATH		Month <u>May</u>		Day <u>18</u>		Year <u>1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Nov 29 1898</u>		9. AGE (In years from birthday) <u>61</u>		10. IF UNDER 1 YEAR Months <u>0</u>		11. IF UNDER 24 HRS. Days <u>0</u>		12. IF UNDER 24 HRS. Hours <u>0</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Maria Van Hasselt</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gray Home</u>		11. BIRTHPLACE (State or foreign country) <u>Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Holland</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (Yes, <u>Unknown</u>) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Married Weight, serves as trustee</u>		Address <u>—</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Acute Congestive heart failure</u>																			
Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u>																			
DUE TO <u>(c)</u>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>—</u>		(County) <u>—</u>		(State) <u>—</u>									
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED <u>May 18, 1959</u>					
EXAMINER'S NAME (Type) <u>James I. Boyd</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/20/59</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Washington National Cem.</u>		22d. LOCATION (City, town, or county) <u>Springfield</u>		(State) <u>Md.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalley's Funeral Home, Mt. Rainier Inc.</u>		ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>MAY 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Hause</u>													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5937

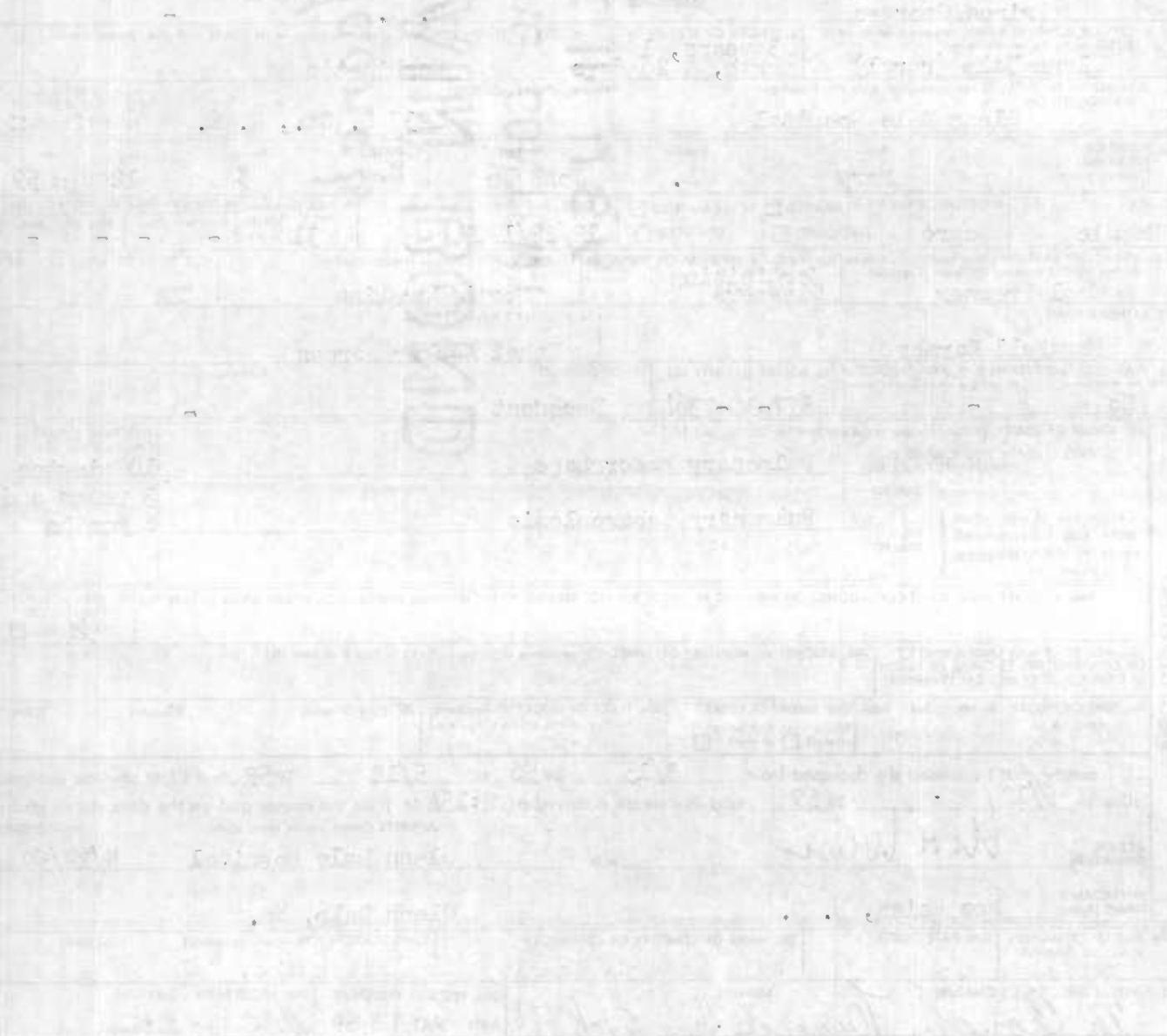
CERTIFICATE OF DEATH

Reg. Dist. No.

05900

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C.		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 3 years, 1 month, & 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1237 D. St., N. E.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary		First	Middle L.	Last Johnson	4. DATE OF DEATH 5	Month 5	Day 12	Year 19 59		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12/22/1927	9. AGE (In years lost birthday) 31 yrs.	IF UNDER 1 YEAR Months —		IF UNDER 24 HRS. Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wool Presser		10b. KIND OF BUSINESS OR INDUSTRY Martinizing Cleaners		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY: USA				
13. FATHER'S NAME Marshall Barnes			14. MOTHER'S MAIDEN NAME Ethel Locker Barnes			Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 577-30-7384		17. INFORMANT Decedent		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO 002 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Pulmonary tuberculosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 3 years and 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 3/15 , 19 56 , to 5/12 , 19 59 , that I last saw the deceased alive on 5/12 , 19 59 , and that death occurred at 2:15 A.M. from the causes and on the date stated above.			ADDRESS (Street, city or town, state) Glen Dale Hospital							
ACTUAL SIGNATURE Moe Weiss			DATE SIGNED 5/12/59							
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.			Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-18-59		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington, Va		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Crouch Funeral Home			ADDRESS 51-1870						24a. REC'D BY REGISTRAR MAY 15 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

STATE OF OKLAHOMA
CITY OF OKLAHOMA CITY



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your office.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05901

Reg. Dist. No.

1 3 5900		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH		05901	
1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 37 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 5505 Landover Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nannie M. Johnston		First Nannie	Middle M.	Last Johnston	4. DATE OF DEATH May 29
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 7-8-74	9. AGE (In years last birthday) 84 yrs.	Month IF UNDER 1 YEAR Months Days Hours Min. Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. Carolina	
13. FATHER'S NAME Warren Barnett		14. MOTHER'S MAIDEN NAME Martha Sanders		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No.		16. SOCIAL SECURITY NO.		17. INFORMANT Blanche M. Shirley; same address as # 2.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9047					
(b) Fractured hip with hip nailing operation					
DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Senility					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home			
20c. TIME OF INJURY Hour 12.15 p.m.		Month, Day, Year 4--8--1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (Nursing)	20f. (City or town) Takoma Park, Pr. Geo.
				(County) Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John J. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DATE SIGNED May 30, 1959			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill	
				22d. LOCATION (City, town, or county) Glendale	
				(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR JUN 2 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Koenig</i>

WISCONSIN STATE EXAMINER'S CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05902

FOR STATE
HEALTH DEPT.

5938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Prince Georges MARYLAND		Maryland Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Hillcrest Heights, Maryland		Hillcrest Heights	
d. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
6 years 5221-32nd Avenue		5221-32nd Avenue	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Kenneth Vasil KAYIAN		Month Day Year May 1 1959	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		Divorced <input type="checkbox"/>	
Dec 28, 1904		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed Connoisseur	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Artin KAYIAN		14. MOTHER'S MAIDEN NAME Mary Kri Korian	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 041-10-1523	
17. INFORMANT Mrs. Margaret Karian, spouse to		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause last. DUE TO (c) Bronchogenic Carcinoma			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 5, 1959		22b. DATE THEREOF May 5, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Suitland Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee Son Wash. D. C.		ADDRESS	
		24a. REC'D BY REGISTRAR MAY 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Krause	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained by the State Board of Health. To FUNERAL DIRECTOR: Page 3 should be used on a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05903

5901 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 38		d. STREET ADDRESS 2503 Bellevue Ave		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Louise	Middle M.	Last King	4. DATE OF DEATH May 30 1959	Month May	Day 30	Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 29, 1889	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 111-11-1111		17. INFORMANT Dorothy Ottaviano	Address 2503 Bellevue Ave, Cheverly, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NEUROGENIC SHOCK DUE TO THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LEFT FRONTAL-PARIETAL CEREBRAL HAEMORRHAGE DUE TO DIABEAT 7 DAYS (c) HYPERTENSIVE ARTERIOSCLEROTIC HEART DUE TO DIABEAT ? YEARS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 20 MAY , 19 59 , to 20 MAY , 19 59 , that I last saw the deceased alive on 29 MAY , 19 59 , and that death occurred at 11:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED 5/30/59								
ACTUAL SIGNATURE Henry R. Wolfe	PHYSICIAN'S NAME (Type) Dr. H. R. Wolfe		M.D. 905 Sheridan St.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6/2/59	22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery			22d. LOCATION (City, town, or county) Prince George, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John H. Jones Co.	ADDRESS 3901 14th St. NW	24a. REC'D BY REGISTRAR JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline				
VS A15 (4) 15M 10/57								

MISSOURI STATE BOARD OF EDUCATION - AUTHORITY TO
ISSUE CERTIFICATE OF DEAN

RECEIVED IN THE LIBRARY OF THE MISSOURI STATE BOARD OF EDUCATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 See: Birth Cert. et

05904

5902

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Linus	Middle Lakshmanan	Last 4. DATE OF DEATH May 20 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 May 1959
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 20 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sitarama Lakshmanan		14. MOTHER'S MAIDEN NAME Florence Mary Lazicki	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0 DUE TO Mult. pul + renal infarcts INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I attended the deceased from May 1, 1959 , to May 20, 1959 , that I last saw the deceased alive on May 19, 1959 , and that death occurred at 1:00 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Louis Mendel M.D. ADDRESS (Street, city or town, state) 4506 College Ave. Wheaton Md DATE SIGNED 5/20/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/59	22c. NAME OF CEMETERY OR CREMATORIAL Gates of Georgia
22d. LOCATION (City, town, or county) Wheaton Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gascha Sons Hyattsville Md		ADDRESS 2077304 X V 4	24a. REC'D BY REGISTRAR DATE MAY 25 '59
		24b. REGISTRAR'S SIGNATURE Barbara S. Hanna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5903

CERTIFICATE OF DEATH

05905

Reg. Dist. No. 1

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 5114 54th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Myrtle	Middle M.	Last Lawrence	4. DATE OF DEATH	Month May 30	Doy 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 3, 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 5114 54th Ave.	IF UNDER 24 HRS. Days Sr. Roger Heights, Md.	Hours 12. CITIZEN OF WHAT COUNTRY?
7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennessee			
13. FATHER'S NAME Alvin Marlin		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT Charles E. Lawrence		Address 5114 54th Ave.	
						INTERVAL BETWEEN ONSET AND DEATH 18 days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Core boro - vascular accident & left hemiplegia							
443X DUE TO Hypertension Cardiovascular Disease over 86							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Electrolyte disturbance							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Electrolyte disturbance							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I attended the deceased from 5-20-59 , 19 59 , to 5-30 , 19 59 , that I last saw the deceased alive on 5-30 , 19 59 , and that death occurred at 12:30P M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 4314 Fallerton St.							
DATE SIGNED Arthur S. Kraus							
ACTUAL SIGNATURE Till Bergemann							
M.D.							
PHYSICIAN'S NAME (Type) Dr. Till Bergemann							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Kline Co.							
ADDRESS 2901-15th St. NW				24a. REC'D BY REGISTRAR JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05906

5939 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY P. G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 25 DC		c. LENGTH OF STAY IN 1b 5 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X None Mitchellville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Darron	Middle St. Claire	Last Lee	4. DATE OF DEATH Month May	Day Year 16 1959
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 May 59	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months 5 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Bernard N. Lee		14. MOTHER'S MAIDEN NAME Agatha B. Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Father Route 2 Box 87, Mitchellville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Atelectasis DUE TO (c) Prematurity INTERVAL BETWEEN ONSET AND DEATH 762.5 5 Hrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy 19	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 16 May 1959 , to 16 May 1959 , that I last saw the deceased alive on 16 May 1959 , and that death occurred at 4:07 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>John A. Moore</i>	M.D.		USAF Hospital Andrews		
PHYSICIAN'S NAME (Type) JOHN A. MOORE CAPT USAF (MC)	Andrews AFB., Washington 25, DC				
22a. BURIAL-CREMATION, REMOVAL (Specify) 5-20-59	22b. DATE THEREOF 5-20-59	22c. NAME OF CEMETERY OR CREMATORIUM Arlington	22d. LOCATION (City, town, or county) Arlington, VA (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARRIS Jr.		ADDRESS P. O. 1432 You Street	24a. REC'D BY REGISTRAR DATE MAY 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - SAN FRANCISCO

CERTIFICATE OF DEATH

2004

2
FOR
HEAL

Please
Page
files
Health

XAMINER: This certificate should be executed within 24 hours after death. If any delay is
writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral o
to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained fo
Q: Page 3 should be used as a hirini-trar
File pages 1 and 2 with the State R

TO DEPUTY MEDIC
execute the certific
A should be forwar
TO FUNERAL DIP

VS. AISME
5M 2/57

STATE
TH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5803

05907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Radiant Valley-Hyattsville		c. LENGTH OF STAY IN lb 10 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6916 Shepherd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Anna	Middle J.	Last Light
4. DATE OF DEATH	Month May	Day 19	Year 1959
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Morrison	14. MOTHER'S MAIDEN NAME Julia Blackin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No			Clinton G. Light; same address as # 2.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive-arteriosclerotic heart disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Diabetes			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED May 19, 1959
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 22, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Suitland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		ADDRESS Hyattsville Maryland.	24a. REC'D BY REGISTRAR DATE MAY 21 '59
			24b. REGISTRAR'S SIGNATURE Arthur & Kraus

STATE OF MASSACHUSETTS
DEPARTMENT OF PUBLIC WELFARE

STATE EXAMINER'S OFFICE TO STATE EXAMINER'S OFFICE

TO THE

EXAMINER

STATE EXAMINER'S OFFICE

NOTICE OF APPOINTMENT

NOTICE OF APPOINTMENT

NOTICE OF APPOINTMENT

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STATE EXAMINER'S OFFICE

NOTICE OF APPOINTMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5940 CERTIFICATE OF DEATH

Reg. Dist. No.

05908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		d. STREET ADDRESS Daisy Lane Route #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Daisy Lane Route #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROLAND FRANCIS LIVINGSTON		First	Middle	Last	4. DATE OF DEATH Month May	Month 16,	Day 1959
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1907	9. AGE (In years last birthday) yrs. 52	12. CITIZEN OF WHAT COUNTRY? IF UNDER 1 YEAR Months U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Business		11. BIRTHPLACE (State or foreign country) Allen, Maryland		12. CITIZEN OF WHAT COUNTRY? IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME Peter F. Livingston		14. MOTHER'S MAIDEN NAME Annie B. Teadbin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-7044		17. INFORMANT Mrs. Freida B. Livingston, Daisy Land, Route 1.		Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE INTERVAL BETWEEN ONSET AND DEATH 527.1 2 years							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) POLYCYTHEMIA 2 years							
DUE TO (c) PULMONARY EMPHYSEMA 5 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/3, 1950 , to 5/16, 1959 , that I last saw the deceased alive on 5/14, 1959 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>C. Louis Mendel, M.D.</i> ADDRESS (Street, city or town, state) 4506 College Ave., College Park, Md. DATE SIGNED 5/17/59							
PHYSICIAN'S NAME (Type) C. LOUIS MENDEL		22b. DATE THEREOF May 20, 1959					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22c. NAME OF CEMETERY OR CREMATORIUM Arnon Cemetery		22d. LOCATION (City, town, or county) Forestville, Maryland, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Maryland,		ADDRESS		24a. REC'D BY REGISTRAR MAY 19 '59		24b. REGISTRAR'S SIGNATURE <i>John S. Jones</i>	

CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD J. MURRAY	65	M	HEART DISEASE
ADDRESS	STREET	CITY	STATE
1234 FAIRFIELD DR.	FAIRFIELD DR.	MARLBOROUGH	GA
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF FUNERAL DIRECTOR		
DR. RICHARDSON, 123 FAIRFIELD DR.	WILLIAMS FUNERAL HOME, 123 FAIRFIELD DR.		
TIME OF DEATH	DATE OF DEATH		
10:00 AM	NOVEMBER 12, 1988		
TIME OF AUTOPSY	DATE OF AUTOPSY		
10:00 AM	NOVEMBER 12, 1988		
NAME OF PERSON SIGNING	RELATIONSHIP		
JOHN W. MURRAY	FATHER		
PRINTED NAME	SIGNATURE		
JOHN W. MURRAY			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

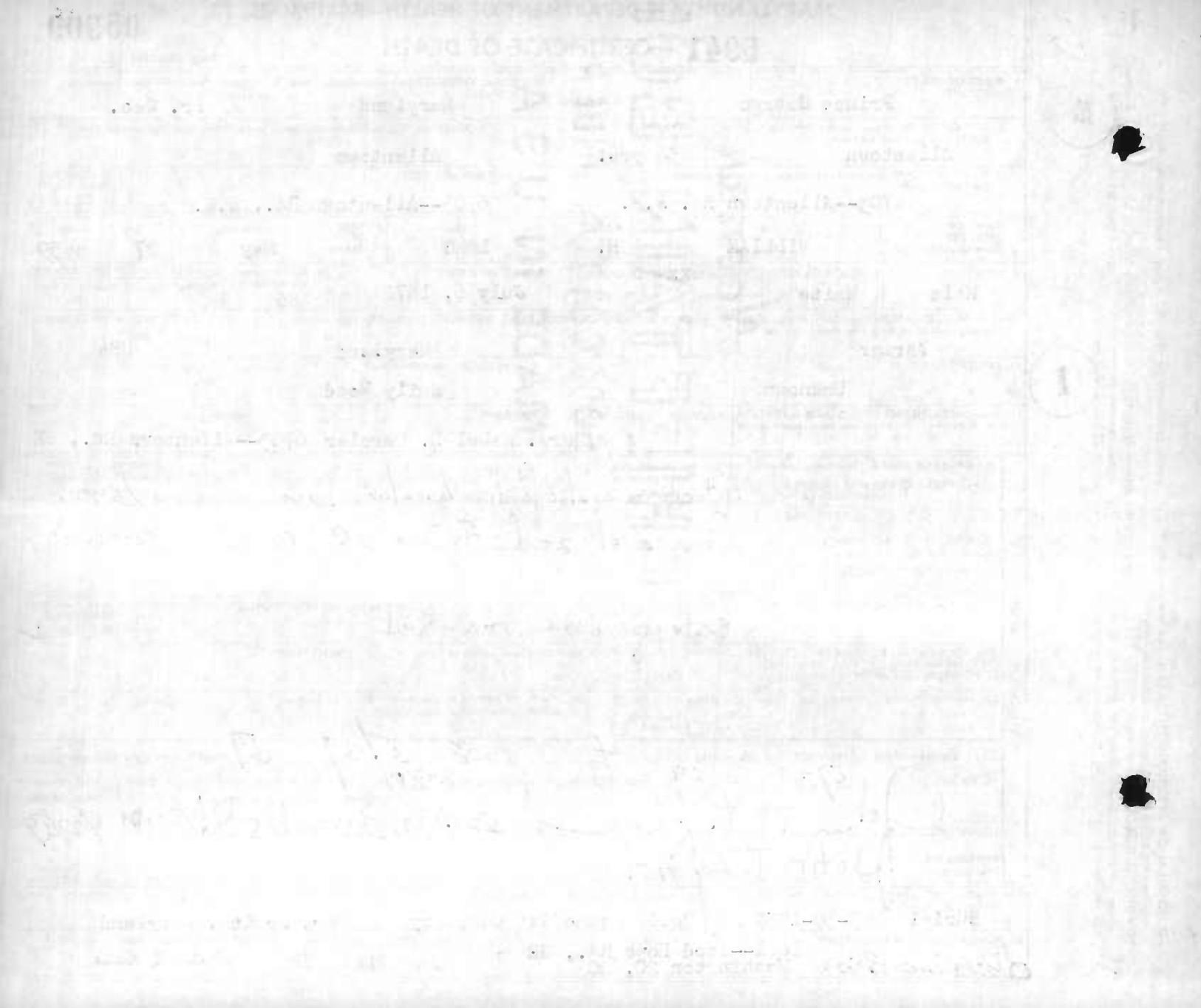
05909

5941 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be affixed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allentown		c. LENGTH OF STAY IN 1b 54 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6703--Allentown Rd. S.E.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allentown				
3. NAME OF DECEASED (Type or print) WILLIAM		First H.	Middle LONG			
4. DATE OF DEATH Month May	Day 27	Year 1959	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1872			
9. AGE (In years lost birthday) 86	10. IF UNDER 1 YEAR Months 86	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Emily Wood				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	INFORMANT Mrs. Mabel L. Oursler			
			Address 6703--Allentown Rd., SE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Ischaemic Cardio-Vascular Dis DUE TO 422.1						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Unknown						
INTERVAL BETWEEN ONSET AND DEATH 15 yr.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Osteoporosis, marked						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4	20f. (City or town) 1956, ta. 3/27, 1959	(County) 1956, ta. 3/27, 1959	(State) 1956, ta. 3/27, 1959
21. I certify that I attended the deceased from 4 , 1956, ta. 3/27, 1959 , that I last saw the deceased alive on 3/27, 1959 , and that death occurred at 843 PM , from the causes and on the date stated above.						
ACTUAL SIGNATURE John T. Lynn		ADDRESS (Street, city or town, state) 5241 St. Bernabas Road, MD 20746				
PHYSICIAN'S NAME (Type) John T. Lynn		DATE SIGNED 9/2/59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-30-1959	22c. NAME OF CEMETERY OR CREMATORIUM Bells Methodist Cemetery	22d. LOCATION (City, town, or county) Camp Spring, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Simeona Bros.		ADDRESS 1661--Good Hope Rd., SE Washington 20, DC	24a. REC'D BY REGISTRAR JUN 1 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05910

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

2 hours

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

**3. NAME OF
DECEASED
(Type or print)**

First

Middle

Last

4. DATE
OF
DEATH

Month
May

22,

Year
19 59

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Male

white

WIDOWED

DIVORCED

7-9-1929

29

Yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lithographer

10b. KIND OF BUSINESS OR INDUSTRY

Lithograph

11. BIRTHPLACE (State or foreign country)

Dist. of Columbia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John E. Lyle

14. MOTHER'S MAIDEN NAME

Phyllis Paddock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes

W.W.2

16. SOCIAL SECURITY NO.

577-36-1441

17. INFORMANT

8205 11th Avenue

John E. Lyle; Hyattsville, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hemorrhage and shock

INTERVAL BETWEEN
ONSET AND DEATH

815X
DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Severence of right femoral artery and

(c)

Cerebral concussion and contusion

2. MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Operator of a motorcycle in collision with a 1957 Ford Convert.

20c. TIME OF INJURY Month, Day, Year

3:00 o.m. May 22 1959

20d. INJURY OCCURRED

While at work Not while at work Highway

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

near Glen Dale, Pr. Geo. Md.

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John T. Maloney, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

May 22, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL

Burial

5-26-59

Arlington National

22d. LOCATION (City, town, or county)

(State)

Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Frank Gevers Sons Co

3605-14 8th Street

MAY 25 '59

Arthur S. Traus

STATEMENT OF MEDICAL EXAMINER CERTIFICATE

State	3
Date	10/20/2003
Name of deceased person	
Age at death	
Cause of death	
Time of death	
Place of death	
Name of physician	
Signature	

17
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Vista		c. LENGTH OF STAY IN 1b transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) John Hansen Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Kermit	Middle Martin	4. DATE OF DEATH May 2, 1959
5. SEX Male	6. COLOR OR RACE Caucasian white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5-4-12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) N. Carolina
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W. 2		16. SOCIAL SECURITY NO. Melda W. Martin; same address as # 2.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Laceration of scalp and cerebral concussion. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A passenger in an automobile in collision with a sand bank.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 5-2-59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, 120f. (City or town) (County) (State) Highway Near Vista, Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John J. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 2, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 5-6-59		22b. DATE THEREOF 5-6-59
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National Cemetery	22d. LOCATION (City, town, or county) (State) Arlington Va.		
23. FUNERAL DIRECTOR'S SIGNATURE James W. Edmonson	24a. REC'D BY REGISTRAR 909 6th St. N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan
DATE MAY 8 '59			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05912

Reg. Dist. No.

5905

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 4911 Fox St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JESSIE	Middle L.	Last McGOWAN	4. DATE OF DEATH	Month May	Day 25,	Year 19 59
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1875	9. AGE (In years old birthday) 83 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Ret.		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Kansas, Oskaloosa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John O. Lyon		14. MOTHER'S MAIDEN NAME Lucille Johnson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. None	17. INFORMANT None	Rose P. Bryant, daughter, 4911 Fox St., Park, Md.	Address College			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)							
Congestive Heart Failure, with Coronary Thrombosis, sudden death Arterio sclerotic heart dis. 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Riverdale, Maryland	(County)	(State)	
21. I certify that I attended the deceased from May 11, 1959, to May 25, 1959, that I last saw the deceased alive on May 25, 1959, and that death occurred at 1243 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riverdale, Maryland DATE SIGNED 5/26/59							
ACTUAL SIGNATURE L. W. Malin							
PHYSICIAN'S NAME (Type)		L. W. MALIN, M. D.				Riverdale, Maryland.	
22a. BURIAL, CREMATION Burial		22b. DATE THEREOF May 28, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Bladensburg, Maryland. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS COMPANY		ADDRESS Riverdale, Maryland.	24a. REC'D BY REGISTRAR MAY 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE

HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5943

05913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City, Md.				c. LENGTH OF STAY IN lb transient										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) N.W. branch of Anacosta River				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First John	Middle Patrick	4. DATE OF DEATH May 24		Month May	Day 24	Year 19 59						
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-20-09		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker				10b. KIND OF BUSINESS OR INDUSTRY Sheet metal				11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Patrick McGowan					14. MOTHER'S MAIDEN NAME Johanna Burns									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-09-6972				17. INFORMANT Leonard W. Crawford; same address as # 2.				Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia														
929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Drowning														
DUE TO (c) Thrombosis of Basilar Artery														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collapsed while walking in shallow water, fell face downward.										
20c. TIME OF INJURY Hour a. m. May 1959				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River				20f. (City or town) Cottage City, Pr. Geo. Md.		(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>John T. Maloney</i>												DATE SIGNED		
EXAMINER'S NAME (Type) John T. Maloney, M.D.												M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, OR TRANSPORTATION Transportation				22b. DATE THEREOF 5/25/59				22c. NAME OF CEMETERY OR CREMATORIUM Gallitzin				22d. LOCATION (City, town, or county) Pennsylvania		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons												ADDRESS Hyattsville, Maryland.		
24a. REC'D BY REGISTRAR DATE MAY 27 '59												24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

MISSOURI STATE DEPARTMENT OF HEALTH - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH NUMBER 100-000000	NAME OF DECEASED JOHN D. SMITH	SEX M	AGE 50	CAUSE OF DEATH HEART DISEASE
ADDRESS 1234 FAIRFIELD DR. KANSAS CITY, MO 64131	TIME OF DEATH 10:00 AM	DATE OF DEATH JULY 15, 1999	TIME OF AUTOPSY 10:00 AM	DATE OF AUTOPSY JULY 16, 1999
EXAMINER'S STATEMENT The deceased died as a result of heart disease.				
<p>REVIEWED AND APPROVED: Dr. John Doe, M.D. State Medical Examiner Missouri State Department of Health Date: July 16, 1999</p>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG244 6-22-59 et

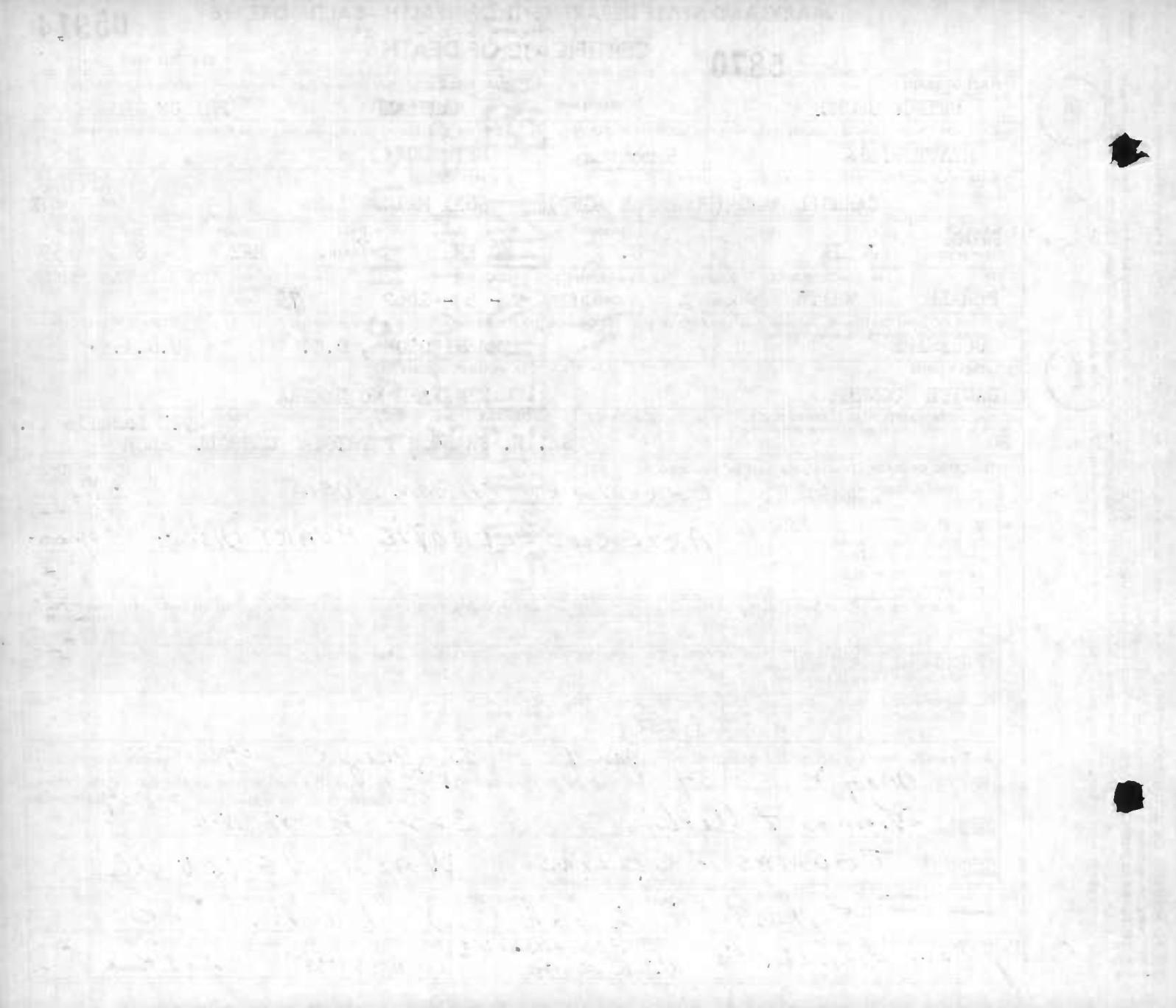
05914

CERTIFICATE OF DEATH

Reg. Dist. No.

5870

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 5 months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY PRINCE GEORGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR(HOME FOR AGED)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		d. STREET ADDRESS 5811 MAIDEN LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JULIA	Middle C.	Last MC KEE	4. DATE OF DEATH MAY 8 1959	Month MAY	Day 8	Year 1959		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 - 5 - 1882	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR 11676	IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DANIEL CONNER		14. MOTHER'S MAIDEN NAME WINIFRED MC NAMARA							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		INFORMANT SR. M. FRANCIS PATRICIA CARROLL MANOR		Address 4922 LaSalle Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO (d) DUE TO								INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 323 H ST NE		(County) Wash	(State) D.C.
21. I certify that I attended the deceased from Jan 1, 1955 to May 8, 1959 that I last saw the deceased alive on May 2, 1959 , and that death occurred at 8:30 AM M. from the causes and on the date stated above. ACTUAL SIGNATURE Thomas F Collins M.D. ADDRESS (Street, city or town, state) 323 H ST NE DATE SIGNED 5-8-59 PHYSICIAN'S NAME (Type) THOMAS F COLLINS WASHINGTON D.C.									
22a. BURIAL, CREMATION, REMOVAL (Specify) 5-11-59		22b. DATE THEREOF 5-11-59		22c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cem		22d. LOCATION (City, town, or county) Wash		(State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lees Sons Co		ADDRESS 300-4th st N.E.		24a. REC'D BY REGISTRAR Arthur E. Kraus		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			
VS A15 (4) 1SM 9/58		DATE MAY 11 '59							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05915

5906

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN lb Laurel - rural		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Laurel Hospital		d. STREET ADDRESS RFD #1		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle RAYMOND	Last MILES	
4. DATE OF DEATH Month May Day 8 Year 19 59	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 30, 1898	9. AGE (In years last birthday) 61 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper	10b. KIND OF BUSINESS OR INDUSTRY Grocery store	
11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Richard Miles		
14. MOTHER'S MAIDEN NAME Emma Sewell	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 212-16-8001	17. INFORMANT Mrs Emma Miles, RFD 1 Laurel Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun Wound of Chest. DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost. (d)		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during attempted robbery.			
20c. TIME OF INJURY Hour 10:10 p.m. Month, Day, Year 5/8 59	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Store	20f. (City or town) Howard	(County) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>Paul F. Guerin</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 5/9/59
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 12, 1959 Any Hill Cem.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Gammie, Laurel, Md</i>	22b. DATE THEREOF ADDRESS			
24a. REC'D BY REGISTRAR DATE MAY 12 '59	24b. REGISTRAR'S SIGNATURE Arthur & Krause			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05916

5907 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN 1b. adm. Oct-15-1959				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MARY	Middle MORROW	4. DATE OF DEATH Month 5 Day 17 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3-1888 yrs. 75			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME John H. Morrow		14. MOTHER'S MAIDEN NAME Mary Dawson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. no	17. INFORMANT Hospital Records Laurel Sanitarium	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO <i>Anoxia (334)</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>cerebral arteriosclerosis (334)</i> DUE TO <i>several yrs.</i> (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Mental deficiency (925)</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Laurel Sanitarium	20f. (City or town) Baltimore	(County)	(State)
21. I certify that I attended the deceased from <u>June</u> , 1959, to <u>May-17-</u> 1959, that I last saw the deceased alive on <u>May-17</u> , 1959, and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.						
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	ADDRESS (Street, city or town, state) ERIKA P. KRAMMER Laurel Sanitarium Maryland			DATE SIGNED 5-17-59		
22a. BURIAL / Cremation / Removal (Specify) Cremation	22b. DATE THEREOF May 20 1959	22c. NAME OF CEMETERY OR CREMATORIAL Laurel	22d. LOCATION (City, town, or county) Baltimore	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraemer	ADDRESS 200 E. Ball St - 1	24a. REC'D BY REGISTRAR MAY 19 1959	24b. REGISTRAR'S SIGNATURE Arthur S. Kraemer			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5819

CERTIFICATE OF DEATH

05917

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>District of Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glenn Dale</i>		c. LENGTH OF STAY IN lb <i>2 yrs 7 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47x-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Glenn Dale Hospital</i>		d. STREET ADDRESS <i>805 "T" St. N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>EVELYN</i>		First	Middle	Lost	4. DATE OF DEATH Month <i>5</i> Day <i>8</i> Year <i>1959</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/27/08</i>	9. AGE (In years lost/birthday) <i>51</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic</i>		10b. KIND OF BUSINESS, OR INDUSTRY <i>service</i>		11. BIRTHPLACE (State or foreign country) <i>N. Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>Edward Bacon</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Day</i>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>deceased</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>002X</i>		DUE TO <i>Pulmonary Tuberculosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4yr 4 mos.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. { (b) (c)					
DUE TO (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pneumonia, both lungs; Diabetes mellitus; Gangrene R. foot toe</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 2b.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <i>5/8 1959</i> , and that death occurred at <i>11:00 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Glenn Dale Hospital</i>	
ACTUAL SIGNATURE <i>Moe Weiss</i>	M.D.				DATE SIGNED <i>5/9/59</i>
PHYSICIAN'S NAME (Type) <i>MOE WEISS MD.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal to D.C.</i>	22b. DATE THEREOF <i>5/9/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Glenn Dale, Md.</i>	22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Flanagan</i>	ADDRESS <i>1222 27th St. N.W. DC</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 12 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Flanagan</i>	

CERTIFICATE OF DEATH

NO. 123

123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5908 CERTIFICATE OF DEATH

Reg. Dist. No.

05918

1. PLACE OF DEATH a. COUNTY Prince George County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 5931 89th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William	First	Middle	Lost	4. DATE OF DEATH May 19 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/18/1917	9. AGE (In years lost birthday) 41 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CONN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Nesgoda		14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. II 223-38-1315		17. INFORMANT Margaret J. Nesgoda, Wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Acute pulmonary edema				24 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Myocardial Infarction					
DUE TO (c)		Occlusion of Left Anterior Descending Coronary				24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Coronary Arteriosclerotic Heart Disease				years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5102 Annapolis Rd, Bladensburg		20f. (City or town) Bladensburg	(County) Md.
21. I certify that I attended the deceased from Oct. 28, 1955 to May 19, 1959 , that I last saw the deceased alive on May 19, 1959 , and that death occurred at 4:35 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5102 Annapolis Rd, Bladensburg, Md.					
ACTUAL SIGNATURE Julius Kauffman		DATE SIGNED 5/19/59					
PHYSICIAN'S NAME (Type) Julius Kauffman		5102 Annapolis Rd, Bladensburg, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/22/59		22c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN		22d. LOCATION (City, town, or county) Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 5801 CLEVELAND AVE RIVERDALE MD.		24a. REC'D BY REGISTRAR MAY 21 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thru	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5944 CERTIFICATE OF DEATH

05919

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince Georges</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Langley Park, Md</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>1028 University Blvd. East</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Langley Park</i>		e. STREET ADDRESS <i>1028 University Blvd. East</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1028 University Blvd. East</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Paul Wilson Nicholson</i>		Fist <i>Paul</i>	Middle <i>Wilson</i>	Last <i>Nicholson</i>	4. DATE OF DEATH <i>May 2nd 1959</i>	Month <i>May</i>	Day <i>2nd</i>	Year <i>1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>9/6/1895</i>	9. AGE (In years, months, days) lost birthday <i>63 yrs. 6 mos. 26 days</i>	IF UNDER 1 YEAR Months <i>6 mos.</i>	IF UNDER 24 HRS. Hours <i>26 hrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sgt. Berg, retired Mel. Police Dept.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington, D.C.</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Charles Nicholson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Kyle</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Paul E. Nicholson, son</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO <i>(b)</i>	INTERVAL BETWEEN ONSET AND DEATH		DUE TO <i>(c)</i>			
DUE TO <i>(c)</i>		<i>Congestive heart disease</i>		<i>Congestive heart disease</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>1500 M. 1746 R.R. 37 M.D.</i>		
ACTUAL SIGNATURE <i>A Magruder Mac Donald</i>						DATE SIGNED <i>1746 R.R. 37 M.D.</i>		
PHYSICIAN'S NAME (Type) <i>A Magruder Mac Donald</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/5/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Colma Manor, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kalloy's Funeral Home Inc.</i>		ADDRESS <i>200-R.R. Line Mt. Rainier, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. King</i>		

CERTIFICATE OF DEATH

NAME OF DECEASED	
JAMES RICHARD FISHER	
MATERIAL TESTED	
BLOOD	
TESTS CONDUCTED	
HIV	
TEST RESULTS	
HIV - POSITIVE	
TESTER'S SIGNATURE	
JANET RAY	
TESTER'S TITLE	
LABORATORY DIRECTOR	
TEST DATE	
JULY 10, 1991	
EXPIRATION DATE	
AUGUST 10, 1991	
TEST NUMBER	
218208	
STATION NUMBER	
1004-09-17	

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

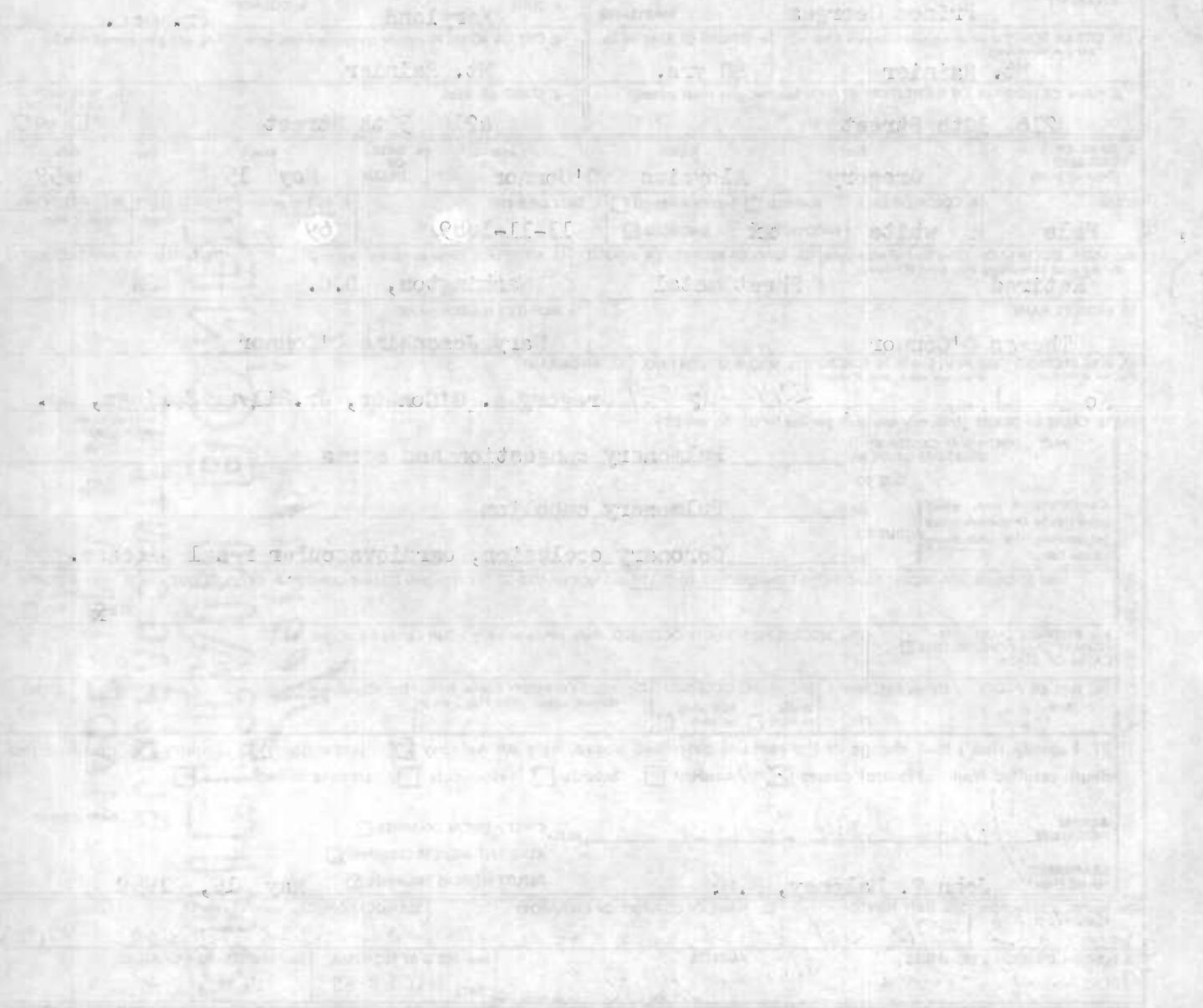
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN lb 40 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4216 30th Street		e. STREET ADDRESS 4216 30th Street	
3. NAME OF DECEASED (Type or print) Gregory		First Gregory	Middle Aloysius
		Last O'Connor	4. DATE OF DEATH Month May Day 15 Year 1959
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		9. AGE (In years for birthday) 68 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Sheet metal		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Thomas O'Connor		14. MOTHER'S MAIDEN NAME Mary Josephine O'Connor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-28-2237 17. INFORMANT Gregory A. O'Connor, Jr. Silver Springs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary congestion and edema		INTERVAL BETWEEN ONSET AND DEATH	
(c) Pulmonary embolism DUE TO Conditions, if any, which gave rise to underlying cause last. (d) Coronary occlusion, cardiovascular renal disease.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED	
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 15, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/59 22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Haller's Funeral Home, Mt. Rainier</i>		ADDRESS 2216 30th Street, Mt. Rainier, Md.	
		24a. REC'D BY REGISTRAR DATE May 18 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MANUAL FOR THE OBSERVATION OF HABITS AND ATTITUDES OF
SOCIAL EXCHANGES IN CHILDREN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5909

CERTIFICATE OF DEATH

Reg. Dist. No.

05921

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina		b. COUNTY Beaufort		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 245 E 2nd St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Grace (N.M.N.) O'Neal (O'Neil)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 23 Jan 1898	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jessie J. Warren		14. MOTHER'S MAIDEN NAME Helen Ricks						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary D. Gray, 5708-84th St. Hyattsville, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0		DUE TO Illiona, right cerebral		INTERVAL BETWEEN ONSET AND DEATH one month				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO 		(c) DUE TO 						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1904 "R" ST, NW, WASH DC		20f. (City or town) Washington, Beaufort Co., N.C.		(County) (State)
21. I certify that I attended the deceased from May 14 , 1959, to May 25 , 1959, that I last saw the deceased alive on May 25 , 1959, and that death occurred at 4, 55 A M, from the causes and on the date stated above.								
ACTUAL SIGNATURE Robert A. Mendelsohn M.D.		ADDRESS (Street, city or town, state) 5/27/59						
DATE SIGNED								
PHYSICIAN'S NAME (Type) Robert A. Mendelsohn M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29th, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Oakdale Cemetery		22d. LOCATION (City, town, or county) Washington, Beaufort Co., N.C.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAY 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas		

13-101
CALIFORNIA STATE DEPARTMENT OF HIGHWAYS - DIVISION 10

CERTIFICATE OF MAIL

RECEIVED - 2000

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05923

CERTIFICATE OF DEATH

Reg. Dist. No.

5871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Md.</i>		c. LENGTH OF STAY IN 1b <i>7 1/2 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll Manor</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>	
d. STREET ADDRESS <i>1707 Columbia Rd</i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George Huntley Palmer</i>		First <i>George</i>	Middle <i>Huntley</i>
3. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Oct. 8, 1888</i>		9. AGE (In years lost birthday) <i>70 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sacristan</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	11. BIRTHPLACE (State or foreign country) <i>England</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>George Frederick Palmer</i>		14. MOTHER'S MAIDEN NAME <i>Ann Susanna Huntley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-44-2973</i>	INFORMANT <i>St. Maureen Therese</i>
17. Address <i>CARROLL MANOR</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>539.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Aesophagitis</i>		3 days	
DUE TO <i>Relation of Aesophageal Stricture</i>		2 yrs.	
DUE TO <i>Aesophageal Hemorrhage</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Hypertensive Cardiopulmonary Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Gastric resection (1954)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 1, 1959</i> to <i>May 3, 1959</i> that I last saw the deceased alive on <i>May 2, 1959</i> and that death occurred at <i>7:30A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Francis P. Hannan M.D. 1511-17th St. N.W. Washington D.C.</i>	
ACTUAL SIGNATURE <i>Francis P. Hannan M.D.</i>		DATE SIGNED <i>May 3, 1959</i>	
PHYSICIAN'S NAME (Type) <i>FRANCIS P. HANNAN M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>5-6-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet</i>
22d. LOCATION (City, town, or county) <i>WASHINGTON D.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Lambrightson</i>		23. ADDRESS <i>1756 1/2 Ave MD</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 5 '59</i>
		24b. REGISTRAR'S SIGNATURE <i>Orling S. Evans</i>	

1921

CERTIFICATE OF OWNERSHIP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5945

CERTIFICATE OF DEATH

Reg. Dist. No.

05924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Berkeley Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Takoma Park</i>		c. LENGTH OF STAY IN lb <i>4 yrs</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings</i>		e. STREET ADDRESS <i>Takoma Park, and 1525 Elson St. Takoma Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1525 Elson St. Takoma Park</i>				d. STREET ADDRESS <i>1525 Elson St. Takoma Park</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Catherine Rose Park</i>		First	Middle	Last	4. DATE OF DEATH <i>May 17 1959</i>	Month	Day	Year	
S. SEX <i>F</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 10, 1873</i>	9. AGE (In years last birthday), yrs. <i>85</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hausfrau</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At home</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>John Dee</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Fanning</i>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Catherine Gill</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>arteriosclerotic cardiovascular disease with congestive heart failure</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i></i> (c) <i></i>		DUE TO <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Carroll Ave</i>		(County) <i>Carroll</i> (State) <i>N.Y.</i>	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>56</i> , to <i>May 17</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>May 17</i> , 19 <i>59</i> , and that death occurred on <i>May 17</i> , 19 <i>59</i> , M., from the causes and on the date stated above.									ACTUAL SIGNATURE <i>J. M. Whiting, M.D.</i> DATE SIGNED <i>5/17/59</i>
PHYSICIAN'S NAME (Type) <i>Takoma Park 12 MD.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>SHIP A.R.</i>		22b. DATE THEREOF <i>5-20-1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Raymonds Cemetery Bronx</i>		22d. LOCATION (City, town, or county) <i>Bronx New York</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. CHAMBERS Co</i>		ADDRESS <i>Riversdale Rd</i>		24a. REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>John E. K.</i>			
VS A15 (4) 1SM 9/55		DATE <i>MAY 20 '59</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5946

CERTIFICATE OF DEATH

05925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS 3918 Elm Street		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Mary	Middle Jane	Last Perry	4. DATE OF DEATH May 8, 1959
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/1/1870	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 5 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Julius Jones			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 17. INFORMANT John Perry — 1225½ Duncan St; N.E. Wash; D.C.		
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) arteriosclerotic heart disease with DUE TO (c) cardiomegaly and myoconus, severe					
INTERVAL BETWEEN ONSET AND DEATH 5 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) see above					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) see above		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 22, 1954 , to 1 May, 1959 , that I last saw the deceased alive on 7 May, 1959 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) M.D. 3435 Benning Rd. N.E.					
DATE SIGNED Robert C. Edwards					
ACTUAL SIGNATURE Robert C. Edwards		PHYSICIAN'S NAME (Type) M.D. 3435 Benning Rd. N.E.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/59	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Edwards		ADDRESS 30 H Street, N.E.	24a. REC'D BY REGISTRAR Curtis & Thorne		24b. REGISTRAR'S SIGNATURE Curtis & Thorne
		DATE MAY 11 '59			

HAWAIIAN STATE DEPARTMENT OF HEALTH - DEATH CERTIFICATES

1999 CERTIFICATE OF DEATH

DECEASED PERSON'S NAME LAST NAME, FIRST NAME, MIDDLE NAME MATERIAL NUMBER	DEATH DATE YEAR	DEATH PLACE ADDRESS	DEATH CODE CODE
DEATH CERTIFICATION I, the undersigned, declare that the above information is true and correct to the best of my knowledge and belief.			
Signature of Person Certifying Date: 10/10/00			
RELATIONSHIP TO DECEASED Husband/Wife Son/Daughter Parent Brother/Sister Other	DECEASED PERSON'S AGE Year Month Day	DECEASED PERSON'S GENDER Male Female	DECEASED PERSON'S RACE White Black Asian/Pacific Islander American Indian/Alaskan Native Other
CAUSE OF DEATH List all causes of death, starting with the primary cause.			
MEDICAL RECORD NUMBER HOSPITAL/CLINIC NAME			
DEATH REPORT NUMBER DEATH REPORT DATE DEATH REPORTER SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5947

CERTIFICATE OF DEATH

05926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cottage City</i>		c. LENGTH OF STAY IN 16 <i>7 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3819-40th Avenue</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cottage City</i>	
3. NAME OF DECEASED (Type or print) <i>Francesco (Frank)</i>		First <i>F</i>	Middle <i>PETRONE</i>
4. DATE OF DEATH <i>May 11 1959</i>	Month <i>May</i>	Day <i>11</i>	Year <i>1959</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/17/1876</i>
9. AGE (In years lost birthday) <i>82 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>	11. BIRTHPLACE (State or foreign country) <i>Italy</i>	12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>
13. FATHER'S NAME <i>Stanley</i>		14. MOTHER'S MAIDEN NAME <i>Petroni Marguerite Montello</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-18-1235</i>	17. INFORMANT <i>Mrs. Yolanda Scarlato, Daughter</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>150X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hr.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Metastatic carcinoma</i>		DUE TO <i>carcinoma of esophagus</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 mo</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-1</i> , 19 <i>59</i> , to <i>5-11</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5-11</i> , 19 <i>59</i> , and that death occurred at <i>11:50 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>2513 Brinkley Rd.</i>	
ACTUAL SIGNATURE <i>R. D. Bauer, M.D.</i>	M.D.	DATE SIGNED <i>5-12-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/15/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet</i>
22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home, Inc.</i>	24a. REC'D BY REGISTRAR ADDRESS <i>Mr. Rainier</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Klaus</i>	DATE <i>MAY 18 '59</i>

WYOMING STATE DEPARTMENT OF HEALTH - THERAPEUTIC

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG243 6-5-59 et

05927

5911

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Prince George</i> MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town <i>Cheverly</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbelt</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George's Gen. Hospital</i>		d. STREET ADDRESS <i>9-16 Laurel Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Willie</i>	Middle <i></i>	Last <i>Pines</i>
4. DATE OF DEATH	Month <i>May</i>	Day <i>28</i>	Year <i>1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 2-1892</i>
9. AGE (In years last birthday) yrs. <i>67</i>		10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <i>Housediotics</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
10c. BIRTHPLACE (State or foreign country) <i>Romania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Habot</i>		14. MOTHER'S MAIDEN NAME <i>Sarah</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Julius Pine</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MULTIPLE LUNG INFARCTIONS</i>	
DUE TO <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 MO.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial infarction</i>		DUE TO <i>2 mos.</i>	
(c) <i>Coronary insufficiency</i>		DUE TO <i>7 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1 May</i> , 1959, to <i>27 May</i> , 1959, that I last saw the deceased alive on <i>25 May</i> , 1959, and that death occurred at <i>2:45 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry R. Wolfe</i>		ADDRESS (Street, city or town, state) <i>905 Sheridan St.</i>	
PHYSICIAN'S NAME (Type) <i>HENRY R. WOLFE</i>		DATE SIGNED <i>5/28/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 5/29-1959</i>		22b. DATE THEREOF <i>5/29-1959</i>	
22c. NAME OF CEMETERY OR CEMETORY <i>Mt Hebron</i>		22d. LOCATION (City, town, or county) (State) <i>Long Island N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i>		24a. REC'D. BY REGISTRAR DATE <i>JUN 1 1959</i>	
ADDRESS <i>4219 9th NW DC</i>		24b. REGISTRAR'S SIGNATURE	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be used for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Landover Hills					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4600 72nd Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marvin		First Lee	Middle Reed	Lost Reed	4. DATE OF DEATH May 18 1959	Month May	Day 18	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Nov. 1904	9. AGE (In years lost birthday) 54 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer		10b. KIND OF BUSINESS OR INDUSTRY Washington Terminal		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME A W Reed				14. MOTHER'S MAIDEN NAME Bertha					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no 417 03 4047		17. INFORMANT Lora C Reed		Address Landover Hills, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastritis</i> DUE TO <i>liver disease</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Bronchitis</i> due to <i>liver disease</i> DUE TO <i>liver disease</i> (c) <i>liver disease</i> due to <i>liver disease</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) College Park	(County) Md.	(State) Md.	
21. I certify that I attended the deceased from 9/15 , 19 59 , to 5/18 , 19 59 , that I last saw the deceased alive on 5/17 , 19 59 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 4506 College Ave College Park Md DATE SIGNED 5/18/59									
ACTUAL SIGNATURE <i>Dr. C.L. Mendel</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 5/20/59							
22b. DATE THEREOF 5/20/59		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR Archie S. Kraus	24b. REGISTRAR'S SIGNATURE Archie S. Kraus		
						DATE MAY 21 '59			

DEPARTMENT OF STATE - DIA

STATE DEPARTMENT

SECRETARY OF STATE
WILLIAM J. CLINTON

15

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05929

5948

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
a. COUNTY	Prince George's MARYLAND	a. STATE	Maryland Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Camps Spring N.O.C.	b. COUNT				
c. LENGTH OF STAY IN lb						
d. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital, give street address)	X Broadway Heights					
Andrews Airforce Hospital	4804 V Street SE	e. IS RESIDENCE ON A FARM?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First: James	Middle: Robert	DATE OF DEATH: May 28 1959			
4. SEX: male	5. COLOR OR RACE: white	6. MARRIED: <input type="checkbox"/> NEVER MARRIED: <input checked="" type="checkbox"/>	7. WIDOWED: <input type="checkbox"/> DIVORCED: <input type="checkbox"/>	8. DATE OF BIRTH: Sept 6, 1940	9. AGE (In years last birthday): 18 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during main part of working life, even if retired): Student	10b. KIND OF BUSINESS OR INDUSTRY: High School Washington DC	11. BIRTHPLACE (State or foreign country): U.S.A.	12. CITIZEN OF WHAT COUNTRY? Address: Mrs Elizabeth Notestein, same as above			
13. FATHER'S NAME: James Robert Reid Jr	14. MOTHER'S MAIDEN NAME: Elizabeth Thomas					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or dates of service): No	16. SOCIAL SECURITY NO.: 17. INFORMANT: Address: Mrs Elizabeth Notestein, same as above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8 DUE TO Asphyxia						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Drowning						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) War swimming in a pond with someone else				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:40 p.m. 5/28/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pond		20f. (City or town) Annapolis (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE: James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED: 5/28/58
EXAMINER'S NAME (Type): JAMES I. BOYD						
22a. BURIAL, CREMATION, REMOVAL (Specify): Burial June 1 st 59		22b. DATE THEREOF: Cedar Hill Cemetery		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS: Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Linthall Ind. (State)
22e. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros. 1661-G 1/2 Hoyer St. Washington D.C.		240. REC'D. BY REGISTRAR: JUN 1 '59		24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus		

STATE DEPARTMENT OF HIGHER EDUCATION
MEMORANDUM FOR STATE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5949 CERTIFICATE OF DEATH

Reg. Dist. No. 05930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the funeral director or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE MARYLAND		b. COUNTY PR G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AVONDALE		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XAVONDALE		d. STREET ADDRESS 14919 RUSSELL AVE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4919 RUSSELL AVE				d. STREET ADDRESS 14919 RUSSELL AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS		First EDWARD	Middle RICKER	Lost 	4. DATE OF DEATH MAY 15 1959	Month MAY	Day 15	Year 1959	
5. SEX MALE		6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1887	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) RETIRED WASH TERMINAL RAILROAD		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME UNKNOWN. LAWRENCE		14. MOTHER'S MAIDEN NAME UNKNOWN ISABELLE BINNIX							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT THOMAS B. RICKER		Address 4301 VAN BUREN ST. UNIVERSITY PARK, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis- DUE TO 260X									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease- DUE TO (c) Diabetes Mellitus- DUE TO 23 months 23 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/18/1957 , 19, to 5/15/1959 , 19, that I last saw the deceased alive on 5/15/1959 , 19, and that death occurred at 4:20 A.M. , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 322-H. St. N.E.									
DATE SIGNED Thomas F. Collins, M.D.									
ACTUAL SIGNATURE Thomas F. Collins		M.D.							
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.		Washington 2, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-18-59		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's		22d. LOCATION (City, town, or county) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE C.W. Chambers Co. Inc. Silverdale, Md.		ADDRESS Silverdale, Md.		24a. REC'D BY REGISTRAR MAY 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 film G243 6-8-59 et

05931

CERTIFICATE OF DEATH

Reg. Dist. No.

5913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Hgts		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Hgts.		d. STREET ADDRESS 618 - 57th Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 618 - 57th Ave.				d. STREET ADDRESS 618 - 57th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK		First C.	Middle .	Last RIPLEY	4. DATE OF DEATH May 30th, 1959	Month May	Day 30	Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1880	9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book binder		10b. KIND OF BUSINESS OR INDUSTRY G.P.O.		11. BIRTHPLACE (State or foreign country) Cameron, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME "Unable to obtain from family"				14. MOTHER'S MAIDEN NAME "Unable to obtain from family"					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Frances R Ripley		Address - same as above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH 5 hours									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute colitis DUE TO 5 days									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Doy, Year Hour o. g. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 5-25 , 19 59 to 5-30-59 , 19 59 , that I last saw the deceased alive on 5-29-59 , 19 59 , and that death occurred at 7:45 AM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 5-30-59									
ACTUAL SIGNATURE John B Degan M.D. DATE SIGNED									
PHYSICIAN'S NAME (Type) JOHN B FEGAN 2210 NACKAWA AVE S.E. WASH DC									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Suitland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Turner			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

105932

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	
Prince George's MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Bellon Park 18 year		Bellon Park	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		5107 9 Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Lost 4. DATE OF DEATH Month Day Year	
Bernard Arthur Rock		January 15 1959	
5. SEX		6. COLOR OR RACE	
Male White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		January 30, 1901 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Instrument maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
England		U.S. C	
13. FATHER'S NAME		14. MOTHER'S MASTERN NAME	
Fred Rock		Margaretha Maillard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Asphyxia	
(b) DUE TO		Due to hanging	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
8:00 a.m. 5/15 1959		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)	
		Home Bellon Park	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		May 15, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial May 18-59		22c. NAME OF CEMETERY OR CREMATORIUM	
		22d. LOCATION (City, town, or county) (State)	
		Cedar Hill Cemetery Scotland Rd	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
James I. Boyd		ADDRESS	
Summer Bros 1661-90 Happy St		24a. REC'D BY REGISTRAR	
Mass 20 Oct		DATE MAY 18 '59	
		24b. REGISTRAR'S SIGNATURE	
		Arthur & June	

STATE OF ILLINOIS
DEPARTMENT OF REVENUE
TAX COMMISSIONER'S OFFICE

STATION
NUMBER



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5914 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05933**

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle Phillip	Last Rode
4. DATE OF DEATH	Month May	Month 10	Day 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-15
9. AGE (In years last birthday) 43	yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Programme Planner		10b. KIND OF BUSINESS OR INDUSTRY Civil Service Commiss.	11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Chester Rode		14. MOTHER'S MAIDEN NAME Catherine Shekel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 390-16-1447	
17. INFORMANT Susan Marie Rode; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure			
DUE TO 442X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chr. Asthma			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Owensboro	(County) Kentucky
(State) 22. BURIAL, CREMATION, TRANSPORTATION		22b. DATE THEREOF 5/12/59	
22c. NAME OF CEMETERY OR CREMATORIAL Owensboro		22d. LOCATION (City, town, or county) Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE F Gaschs Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Krause	
MEDICAL CERTIFICATION			
I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D.	DATE SIGNED May 11, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF PUBLIC HEALTH EXAMINER'S CERTIFICATE

STATE
1930

100-11

1930-128

1930-128

1930-128

1930-128

March 1930

For the State of Missouri

Missouri State Board of Health
Health Commissioner
State Health Officer

Health Commissioner
State Health Officer

1930-128

1930-128

1930-128

1930-128

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1930-128

1930-128

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

115934

5872 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY IN 1b 15 months				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HYATTSVILLE Convalescent & Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Pearl	Middle Christine	Last Sampson	4. DATE OF DEATH	Month May	Day 16	Year 1959
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Oct. 16, 1888	9. AGE (In years lost birthday) 70 yrs.	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Jacob Anderson		14. MOTHER'S MAIDEN NAME Christine Brackman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT - Son Cecil Sampson - 3213 Varnum St.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> <u>33IX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1953</u> , 19, to <u>May 16</u> , 1959, that I last saw the deceased alive on <u>May 14</u> , 1959, and that death occurred at <u>7:34</u> M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Leon L. Gallin MD</u>		ADDRESS (Street, city or town, state) <u>7206 Clarendon Rd. W. Hyattsville</u> DATE SIGNED <u>Maryland</u>						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5118-59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill</u>			22d. LOCATION (City, town, or county) <u>Suitland Md.</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>				ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	
JAMES R. HARRIS	
ADDRESS	
101 W. 10TH ST.	
CITY	
BALTIMORE	
STATE	
MD	
AGE	
75	
SEX	
M	
RACE	
W	
MATERIAL TESTED	
BLOOD	
TESTS	
HIV	
TESTED	
POSITIVE	
TESTER	
LABORATORY	
MDH	
TEST DATE	
10/10/01	
DEATH DATE	
10/10/01	
DEATH PLACE	
HOME	
TIME OF DEATH	
10:00 AM	
CAUSE OF DEATH	
HEART DISEASE	
MANNER OF DEATH	
NATURAL	
CERTIFYING PHYSICIAN	
DR. JAMES R. HARRIS	
SIGNATURE	
DR. JAMES R. HARRIS	
PRINT NAME	
JAMES R. HARRIS	
SIGNATURE	
DR. JAMES R. HARRIS	
PRINT NAME	
JAMES R. HARRIS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05935

5951 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo's Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park		c. LENGTH OF STAY IN 1b 30 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park		d. STREET ADDRESS 4620- Howe Ave., S.E.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4620 -Howe Ave. S.E.				d. STREET ADDRESS 4620- Howe Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MAMIE		First	Middle	Last	4. DATE OF DEATH May 15th	Month	Day	Year 19 59
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10- 1888		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		INFORMANT Rufus H. Satterfield		Address Same as # 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis - pneumonia DUE TO 491 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____								
INTERVAL BETWEEN ONSET AND DEATH 4 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral vascular accident								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 19 May 15, 1959								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Suitland, Maryland		(County) Suitland, Maryland	(State) Maryland
21. I certify that I attended the deceased from Dec 15, 1948 to May 15, 1959 that I last saw the deceased alive on May 14, 1959 , and that death occurred at 12- N.Y. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5/15/59 DATE SIGNED ACTUAL SIGNATURE Bernard Katzen								
PHYSICIAN'S NAME (Type) BERNARD KATZEN 3550 Minn., Ave. S. E. Wash., D.C.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May-18-59		22c. NAME OF CEMETERY OR CREMATORIUM Chalk Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers ADDRESS 1661- Good Hope Rd. S.E. Washington 20, D.C.								
24a. REC'D BY REGISTRAR MAY 18 '59					24b. REGISTRAR'S SIGNATURE Arthur & Thomas			

HIGGINS STADIUM 1982

Yankee Stadium

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05938

5952 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN 1b 8½ yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton - Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Linden Street				d. STREET ADDRESS Linden Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Karl Middle Schuerger Last (Type or print)				4. DATE OF DEATH Month May Day 20 Year 1959 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 12, 1893		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired mechanic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John George Schuerger				14. MOTHER'S MAIDEN NAME Dora W. Fensahrens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. No. 1 917		17. INFORMANT Wife		Address Linden St. Clinton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure, 3 weeks							
422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Myocarditis 4 yrs.							
DUE TO (c) Mitral regurgitation 5 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 19, 1959, to May 19, 1959, that I last saw the deceased alive on May 19, 1959, and that death occurred at 7:30M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Roy T. Dunmire</u> M.D. PHYSICIAN'S NAME (Type) Dr. Roy T. Dunmire, 119 - 8th St. S. E. Wash. D. C.							
22a. BURIAL, CREMATION, REBURNING (Specify) Burial		22b. DATE THEREOF 5-22 59		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Ft Myer, VA. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				ADDRESS		24a. REC'D BY REGISTRAR Date MAY 22 '59	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05937

Reg. Dist. No.

5915

1. PLACE OF DEATH

a. COUNTY

Prince George's MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

Hudson armad

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hosp

3. NAME OF
DECEASED
(Type or print)

First Middle
Harold Egel Sealock

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED b. DATE OF BIRTH

WIDOWED DIVORCED

Nov 7, 1929

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Reparman Telephone Co

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

District of Columbia U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Harold Sealock

14. MOTHER'S MAIDEN NAME

Annie Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Thomas Sealock, Boulevard Hts, Md

Address 800 Rogers St

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

DUE TO

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.

(d)

DUE TO

(e)

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(f)

DUE TO

Conditions, if any, which gave rise to immediate cause (f), stating the underlying cause last.

(g)

DUE TO

Conditions, if any, which gave rise to immediate cause (g), stating the underlying cause last.

(h)

DUE TO

Conditions, if any, which gave rise to immediate cause (h), stating the underlying cause last.

(i)

DUE TO

Conditions, if any, which gave rise to immediate cause (i), stating the underlying cause last.

(j)

DUE TO

Conditions, if any, which gave rise to immediate cause (j), stating the underlying cause last.

(k)

DUE TO

Conditions, if any, which gave rise to immediate cause (k), stating the underlying cause last.

(l)

DUE TO

Conditions, if any, which gave rise to immediate cause (l), stating the underlying cause last.

(m)

DUE TO

Conditions, if any, which gave rise to immediate cause (m), stating the underlying cause last.

(n)

DUE TO

Conditions, if any, which gave rise to immediate cause (n), stating the underlying cause last.

(o)

DUE TO

Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.

(p)

DUE TO

Conditions, if any, which gave rise to immediate cause (p), stating the underlying cause last.

(q)

DUE TO

Conditions, if any, which gave rise to immediate cause (q), stating the underlying cause last.

(r)

DUE TO

Conditions, if any, which gave rise to immediate cause (r), stating the underlying cause last.

(s)

DUE TO

Conditions, if any, which gave rise to immediate cause (s), stating the underlying cause last.

(t)

DUE TO

Conditions, if any, which gave rise to immediate cause (t), stating the underlying cause last.

(u)

DUE TO

Conditions, if any, which gave rise to immediate cause (u), stating the underlying cause last.

(v)

DUE TO

Conditions, if any, which gave rise to immediate cause (v), stating the underlying cause last.

(w)

DUE TO

Conditions, if any, which gave rise to immediate cause (w), stating the underlying cause last.

(x)

DUE TO

Conditions, if any, which gave rise to immediate cause (x), stating the underlying cause last.

(y)

DUE TO

Conditions, if any, which gave rise to immediate cause (y), stating the underlying cause last.

(z)

DUE TO

Conditions, if any, which gave rise to immediate cause (z), stating the underlying cause last.

(aa)

DUE TO

Conditions, if any, which gave rise to immediate cause (aa), stating the underlying cause last.

(bb)

DUE TO

Conditions, if any, which gave rise to immediate cause (bb), stating the underlying cause last.

(cc)

DUE TO

Conditions, if any, which gave rise to immediate cause (cc), stating the underlying cause last.

(dd)

DUE TO

Conditions, if any, which gave rise to immediate cause (dd), stating the underlying cause last.

(ee)

DUE TO

Conditions, if any, which gave rise to immediate cause (ee), stating the underlying cause last.

(ff)

DUE TO

Conditions, if any, which gave rise to immediate cause (ff), stating the underlying cause last.

(gg)

DUE TO

Conditions, if any, which gave rise to immediate cause (gg), stating the underlying cause last.

(hh)

DUE TO

Conditions, if any, which gave rise to immediate cause (hh), stating the underlying cause last.

(ii)

DUE TO

Conditions, if any, which gave rise to immediate cause (ii), stating the underlying cause last.

(jj)

DUE TO

Conditions, if any, which gave rise to immediate cause (jj), stating the underlying cause last.

(kk)

DUE TO

Conditions, if any, which gave rise to immediate cause (kk), stating the underlying cause last.

(ll)

DUE TO

Conditions, if any, which gave rise to immediate cause (ll), stating the underlying cause last.

(mm)

DUE TO

Conditions, if any, which gave rise to immediate cause (mm), stating the underlying cause last.

(nn)

DUE TO

Conditions, if any, which gave rise to immediate cause (nn), stating the underlying cause last.

(oo)

DUE TO

Conditions, if any, which gave rise to immediate cause (oo), stating the underlying cause last.

(pp)

DUE TO

Conditions, if any, which gave rise to immediate cause (pp), stating the underlying cause last.

(qq)

DUE TO

Conditions, if any, which gave rise to immediate cause (qq), stating the underlying cause last.

(rr)

DUE TO

Conditions, if any, which gave rise to immediate cause (rr), stating the underlying cause last.

(ss)

DUE TO

Conditions, if any, which gave rise to immediate cause (ss), stating the underlying cause last.

(tt)

DUE TO

Conditions, if any, which gave rise to immediate cause (tt), stating the underlying cause last.

(uu)

DUE TO

Conditions, if any, which gave rise to immediate cause (uu), stating the underlying cause last.

(vv)

DUE TO

Conditions, if any, which gave rise to immediate cause (vv), stating the underlying cause last.

(ww)

DUE TO

Conditions, if any, which gave rise to immediate cause (ww), stating the underlying cause last.

(xx)

DUE TO

Conditions, if any, which gave rise to immediate cause (xx), stating the underlying cause last.

(yy)

DUE TO

Conditions, if any, which gave rise to immediate cause (yy), stating the underlying cause last.

(zz)

DUE TO

Conditions, if any, which gave rise to immediate cause (zz), stating the underlying cause last.

(aa)

DUE TO

Conditions, if any, which gave rise to immediate cause (aa), stating the underlying cause last.

(bb)

DUE TO

Conditions, if any, which gave rise to immediate cause (bb), stating the underlying cause last.

(cc)

DUE TO

Conditions, if any, which gave rise to immediate cause (cc), stating the underlying cause last.

(dd)

DUE TO

Conditions, if any, which gave rise to immediate cause (dd), stating the underlying cause last.

(ee)

DUE TO

Conditions, if any, which gave rise to immediate cause (ee), stating the underlying cause last.

(ff)

DUE TO

Conditions, if any, which gave rise to immediate cause (ff), stating the underlying cause last.

(gg)

DUE TO

Conditions, if any, which gave rise to immediate cause (gg), stating the underlying cause last.

(hh)

DUE TO

Conditions, if any, which gave rise to immediate cause (hh), stating the underlying cause last.

(ii)

DUE TO

Conditions, if any, which gave rise to immediate cause (ii), stating the underlying cause last.

(jj)

DUE TO

Conditions, if any, which gave rise to immediate cause (jj), stating the underlying cause last.

(kk)

DUE TO

Conditions, if any, which gave rise to immediate cause (kk), stating the underlying cause last.

(ll)

DUE TO

Conditions, if any, which gave rise to immediate cause (ll), stating the underlying cause last.

(mm)

DUE TO

Conditions, if any, which gave rise to immediate cause (mm), stating the underlying cause last.

(nn)

DUE TO

Conditions, if any, which gave rise to immediate cause (nn), stating the underlying cause last.

(oo)

DUE TO

Conditions, if any, which gave rise to immediate cause (oo), stating the underlying cause last.

(pp)

DUE TO

Conditions, if any, which gave rise to immediate cause (pp), stating the underlying cause last.

(qq)

DUE TO

Conditions, if any, which gave rise to immediate cause (qq), stating the underlying cause last.

(rr)

DUE TO

Conditions, if any, which gave rise to immediate cause (rr), stating the underlying cause last.

(ss)

DUE TO

Conditions, if any, which gave rise to immediate cause (ss), stating the underlying cause last.

(tt)

DUE TO

Conditions, if any, which gave rise to immediate cause (tt), stating the underlying cause last.

(uu)

DUE TO

Conditions, if any, which gave rise to immediate cause (uu), stating the underlying cause last.

(vv)

DUE TO

Conditions, if any, which gave rise to immediate cause (vv), stating the underlying cause last.

(ww)

DUE TO

Conditions, if any, which gave rise to immediate cause (ww), stating the underlying cause last.

(xx)

DUE TO

Conditions, if any, which gave rise to immediate cause (xx), stating the underlying cause last.

(yy)

DUE TO

Conditions, if any, which gave rise to immediate cause (yy), stating the underlying cause last.

(zz)

DUE TO

Conditions, if any, which gave rise to immediate cause (zz), stating the underlying cause last.

(aa)

DUE TO

Conditions, if any, which gave rise to immediate cause (aa), stating the underlying cause last.

(bb)

DUE TO

Conditions, if any, which gave rise to immediate cause (bb), stating the underlying cause last.

(cc)

DUE TO

Conditions, if any, which gave rise to immediate cause (cc), stating the underlying cause last.

(dd)

WISCONSIN STATE DEPARTMENT OF MINES - CAPITAL WISE
MINERAL EXAMINER'S CERTIFICATE OF DEATH

1910

50

1

2

1910

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05938

5953 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Dale</i>	c. LENGTH OF STAY IN lb <i>3 days</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dist. of Columbia</i>	b. COUNTY <i>Washington 47x-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Glen Dale Hosp.</i>	d. STREET ADDRESS <i>2556 University Pl. N.W.</i>	e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>JOSEPH HENRY SLAUGHTER</i>	First <i>JOSEPH</i>	Middle <i>HENRY</i>	Last <i>SLAUGHTER</i>	4. DATE OF DEATH Month <i>51</i> Day <i>29</i> Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/6/1877</i>	9. AGE (In years lost/birthday) <i>82 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building Management</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>
13. FATHER'S NAME <i>Eli Slaughter</i>		14. MOTHER'S MAIDEN NAME <i>Ella Wetherz</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Deceased</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY FIBROSIS & EMPHYSEMA</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>002X</i>		(b) DUE TO <i>PULMONARY TUBERCULOSIS</i>	(c)	INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ARTERIOSCLEROTIC HEART DISEASE</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Glenn Dale Hosp.</i>	20f. (City or town) <i>Glen Dale, Md.</i>
21. I certify that I attended the deceased from alive on <i>5/29/59</i> , and that death occurred at <i>Glen Dale Hosp.</i>		1959 to 1959, 1959, that I last saw the deceased M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Glen Dale, Md.</i>		
ACTUAL SIGNATURE <i>Moisie Weiss</i>		DATE SIGNED <i>5/30/59</i>		
PHYSICIAN'S NAME (Type) <i>MOE WEISS M.D.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3-31-59</i>	22b. DATE THEREOF <i>3-31-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Lincoln Memorial</i>	22d. LOCATION (City, town, or county) <i>Saintland Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Murray & Sons</i>		ADDRESS	24a. REC'D BY REGISTRAR <i>16073</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
VS A1S (4) 1SM 10/57		DATE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

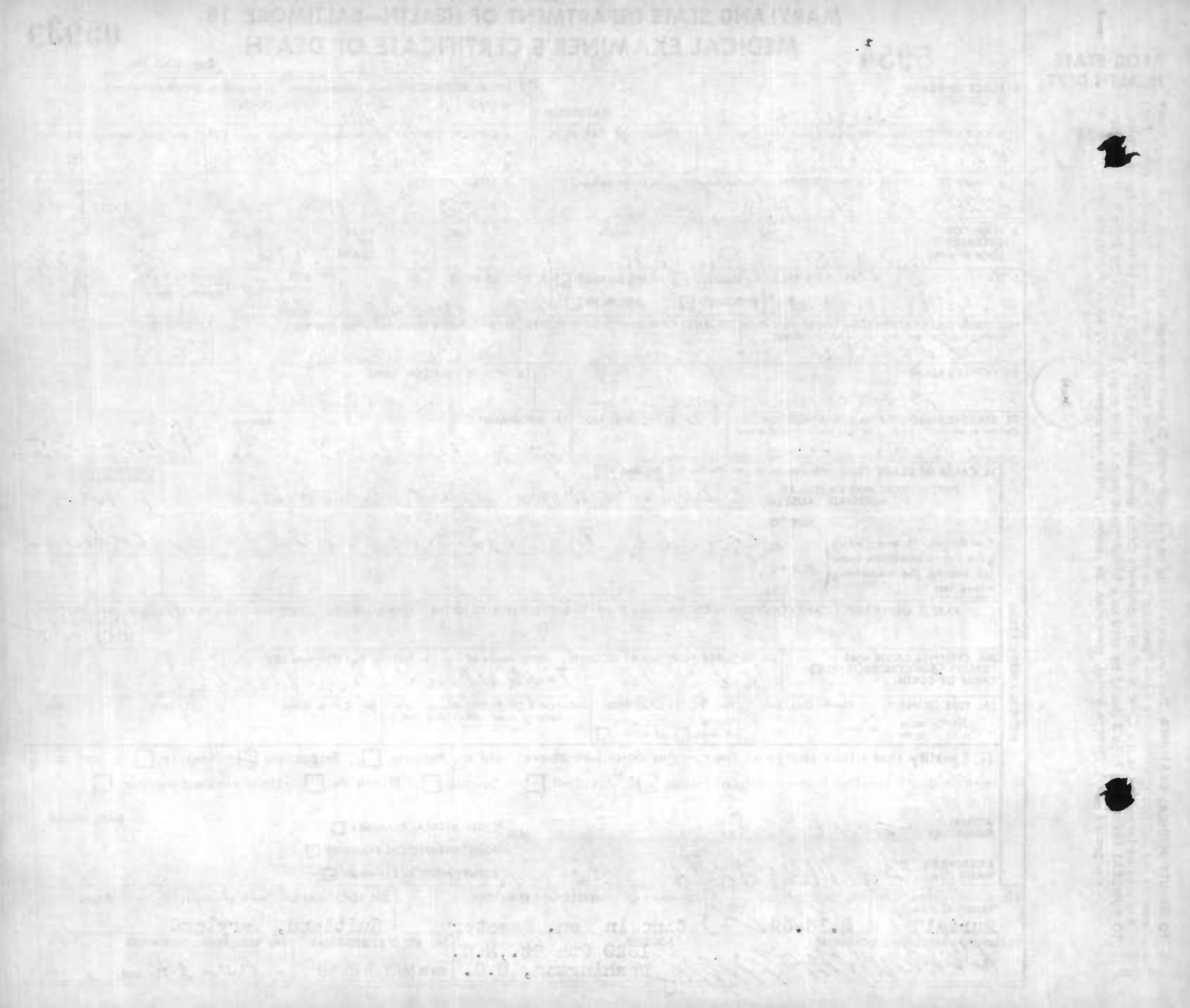
5954

Item 1, Film G242 5/21/59 cap

Reg. Dist. No.

05939

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince George's MARYLAND		a. STATE West Columbia b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓	
Rural Washington 10 days		2423 - E St NW - Washington DC	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 2423 E St NW - DC	
6229 Oxon Hill Rd., Private Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Louis	Middle Smith
4. DATE OF DEATH		Month May	Day 12
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
Male Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 191906 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		Farmer	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
So Carolina		ZL S	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Morgan Smith		Jola Sanders	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
Unknown		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO acute coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to immediate cause (b) DUE TO General arteriosclerosis		Unknown	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
Indigestion - Took Alka-Seltzer			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or Town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Paul Crandall		DATE SIGNED	
EXAMINER'S NAME (Type) Paul Crandall Actuary		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-18-59	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 1820 9th St., N.W. Lincoln Mem. Cemetery Washington, D.C.		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Dolores McGinn		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE MAY 18 '59 Arthur L. Thorne	
VS. A15ME 5M 2/57			



1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5916 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05940

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 809 West Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
f. STREET ADDRESS 809 West Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Novella		First Novella	Middle Smith
4. DATE OF DEATH May 23	Month May	Day 23	Year 1959
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-08
9. AGE (In years last birthday) 51	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Minutes 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William D. Rogers		14. MOTHER'S MAIDEN NAME Arcania Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Elitha Rogers; Rt. 1, Box 85 A, Laurel, Md.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Acute congestive heart failure	
DUE TO (c)		Cardiovascular renal disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED May 23, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/59	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bacon Chaple		22d. LOCATION (City, town, or county) (State) A.A. Co Laurel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ridgley Selby Laurel Md. 1200 Snowden Pl.		24a. REC'D BY REGISTRAR MAY 27 '59	
		24b. REGISTRAR'S SIGNATURE Arthur & Thomas	

MISSOURI STATE BOARD OF MEDICAL EXAMINERS

MEDICAL EXAMINERS CERTIFICATE

STATE FOR
MISSOURI

80-20000-00000

Exhibit

Document No. 800

Exhibit

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Exhibit - Exhibit

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5917 CERTIFICATE OF DEATH

Reg. Dist. No.

05941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 1217 Madison St.,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Benjamin Rush		First	Middle	Last	4. DATE OF DEATH May 10, 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12- -67		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape Gardiner		10b. KIND OF BUSINESS OR INDUSTRY Md. University		11. BIRTHPLACE (State or foreign country) Poolesville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert Smeot			14. MOTHER'S MAIDEN NAME Margaret White					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Nettie B. Smeot,		Address 4317 Madison St., HYATTSVILLE, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days		
Cerebral Thrombosis thus leads to heart Disease Congestive Heart Failure						10 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bladensburg	(County) Maryland	(State) MD
21. I certify that I attended the deceased from 4-17-59 , 19 59 , to 5-10 , 19 59 , that I last saw the deceased alive on 5-10-59 , 19 59 , and that death occurred at 7:05 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE John P. Clum						ADDRESS (Street, city or town, state) 610 43rd Ave		
PHYSICIAN'S NAME (Type) Dr. John Clum						DATE SIGNED Hyattsville Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF May 13, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Bladensburg		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.			ADDRESS RIVERDALE, MARYLAND.			24a. REC'D BY REGISTRAR MAY 12 '59	24b. REGISTRAR'S SIGNATURE John P. Clum	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5875

CERTIFICATE OF DEATH

05942

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Prince Georges MARYLAND		Maryland Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Takoma Park	3 yrs	Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A CAMPUS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
6805 Red Top Road	'6805 Red Top Road		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Pamela Lee Springmann			
4. DATE OF DEATH	Month	Day	Year
	May	2	1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	DATE OF BIRTH
Female Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		June 7, 1950
9. AGE (In years lost birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
8 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	School	Takoma Park, Md	U. S. A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Fague K. M. Springmann	Vivian Lauretta Willard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	—	F.K.M. Springmann	Takoma Park Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cirrhosis of liver, Splenomegaly, ascites</i> DUE TO 292.4 7 mo.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hemochromatosis</i> DUE TO 18 mo.			
(c) <i>Aplastic anemia</i> 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Thrombocytopenic purpura and Nephrosis</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour p. m.	19	White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 10, 1958, to May 2, 1959, that I last saw the deceased alive on May 2, 1959, and that death occurred at 5:32 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
Wallace N. Mook, M.D.		7701 Carroll Ave. 5/2/59	
PHYSICIAN'S NAME (Type)			
Wallace N. Mook, M.D. Takoma Park 12 Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	May 4, 1959	George Washington Cemetery	Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR
J. P. DeMaio Jr. - Alex Va.			24b. REGISTRAR'S SIGNATURE
			Arthur S. Thorne

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5955

05943

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b 2½ Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bank of Potomac River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington 47X-3	
3. NAME OF DECEASED (Type or print) ROBERT MASON STAPLES		4. DATE OF DEATH May Month 21st, Day Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 2nd, 1904
			9. AGE (In years last birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deck Hand		10b. KIND OF BUSINESS OR INDUSTRY Smoot Sand & Gravel	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest Staples		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-22-4641 17. INFORMANT Address Mrs. Doris Dahlstrom, 2431--E--St. N.W., Wash. DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASES. CONDITIONS GIVEN IN PART I (if any) AND PART II (if any) ARE CONSIDERED IN DETERMINING THE CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH was in such a poor state of preservation that cause could not be definitely determined			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 22nd, 1959
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 23rd, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Washington Nat'l Cem.	22d. LOCATION (City, town, or county) (State) Suitland Rd., Pr. Geo. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamber's Company, Riverdale, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 26 '59
			24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>

FOR STATE
HEALTH DEPT.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5918 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05944

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 5 days	b. COUNTY Prince Georges
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Capitol Heights	
d. STREET ADDRESS 1621--60th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First COLLEEN	Middle CATHERINE	Last STRINE
4. DATE OF DEATH May 22nd	Month May	Doy 22nd	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 21st, 1954
	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years from birth) 4 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None--Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul F. Strine		14. MOTHER'S MAIDEN NAME Colleen C. Miles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Colleen C. Strine, 621--60th Ave. Capitol Hgts, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage & Shock 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Comminuted fracture of skull DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by automobile	
20c. TIME OF INJURY Hour 4:00 p.m. Month, Day, Year 5/17 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Capitol Hgts, Pr. Geo. Co. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 23rd, 1959
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 27, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat.	22d. LOCATION (City, town, or county) Ft Myer Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 1 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur J. Trahan</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05945

5956 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4300--Branch Ave S.E.				d. STREET ADDRESS 4300--Branch Ave. S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD		First	Middle	Last	4. DATE OF DEATH Month May	Day 5th	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 13th, 1883	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard T. Swann		14. MOTHER'S MAIDEN NAME Rebecca Brooks					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Effie M. Swann		Address 4300--Branch Ave., S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) coronary arteriosclerosis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED Hour a.m. 19 While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19							
21. I certify that I attended the deceased from 11 - 30 , 19 57 , to May 5 , 19 59 that I last saw the deceased alive on May 1 - , 19 59 , and that death occurred at 11 30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
A. Schwartzman M.D. 2007 Nichols Ave. St., Ward 2E							
ACTUAL SIGNATURE A. Schwartzman		PHYSICIAN'S NAME (Type) A. Schwartzman					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-59		22c. NAME OF CEMETERY OR CREMATORIUM St. Barnabas		22d. LOCATION (City, town, or county) Oxon Hill (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Seminis Bros		ADDRESS 1661 Good Hope Rd., SE Wash. 20 DC		24a. REC'D BY REGISTRAR DATE MAY 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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1

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for future files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05948

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First: Iris	Middle: Tanner	4. DATE OF DEATH May 16, Month Day Year 19 59
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME William McGill		14. MOTHER'S MAIDEN NAME Myrtle Clarke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Roland Dennis Tanner; same address as # 2.
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO 433.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ventricular fibrillation DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congenital heart disease; interatrial septal defect.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Colmar Manor, Md.	(County) Colmar Manor (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 17, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.			
22a. BURIAL, CREMATION, MOVEMENT (Specify) Burial	22b. DATE THEREOF 5/19/59	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		ADDRESS Hyattsville, Maryland.	24a. REC'D BY REGISTRAR DATE MAY 21 '59
			24b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5920

CERTIFICATE OF DEATH

Reg. Dist. No.

05947

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 hrs				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Baby Boy "B"	Middle Taylor	Last Month Day Year May 15 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 May 1959			
9. AGE (In years lost birthday) yrs. 1	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Edward Taylor		14. MOTHER'S MAIDEN NAME Joyce Kruger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 776X		16. SOCIAL SECURITY NO.	17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20d. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 3,10A	(County) Landover Hills, Md.	(State) Md.
21. I certify that I attended the deceased from 5/15/1959 to 5/15/1959 , that I last saw the deceased alive on 5/15/1959 , and that death occurred at 3,10A , M, from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Dr. Fred. Musser.</i>	ADDRESS (Street, city or town, state) 4410 74th Ave			DATE SIGNED 5/16/1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 6/5/59	22c. NAME OF CEMETERY OR CREMATORIAL Prince George's General Hospital, Cheverly, Md.	22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry W. Penn Jr.</i>	ADDRESS Administrator.	24a. REC'D BY REGISTRAR JUN 8 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

REGISTRATION CERTIFICATE OF DESIGN

STATE OF CALIFORNIA - ALAMEDA COUNTY



18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

Items 18&21 Film 2438-77 Ans MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05948

Reg. Dist. No.

5957

1. PLACE OF DEATH
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chillum-Hyattsville

c. LENGTH OF STAY IN lb
transient

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Ager and Riggs Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY Pr. Geo.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Chillum Heights-Hyattsville

d. STREET ADDRESS

6610 Riggs Road

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First Anthony

Middle George

Last Vanagas

4. DATE
OF
DEATH

May

12,

19 59

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

5-6-10

9. AGE (In years
last birthday)

49

yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plate printer

10b. KIND OF BUSINESS OR INDUSTRY

Bu. of Ingraving

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Ignaius Vanagas

14. MOTHER'S MAIDEN NAME

Magdalene

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

Yes

W.W.2

16. SOCIAL SECURITY NO.

101-05-9163

17. INFORMANT

7400 18th Ave.

George F. Vanagas; Hyattsville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral edema and pulmonary edema

INTERVAL BETWEEN
ONSET AND DEATH

431 X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Congestive heart failure

DUE TO

Idiopathic

(c)

2. MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

John T. Maloney

DATE SIGNED

EXAMINER'S
NAME (Type)

John T. Maloney, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

May 13, 1959

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF
5/15/59

22c. NAME OF CEMETERY OR CREMATORIUM
Arlington National

22d. LOCATION (City, town, or county)
Arlington (State) Va.

23. FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons

4739 Baltimore Avenue

Hyattsville, Maryland

24a. REC'D BY REGISTRAR
MAY 15 '59

DATE

24b. REGISTRAR'S SIGNATURE

Arthur L. Krause

2202 Cherry Ave
Cherry, Tex.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 9 Film G242 5-13-59 et
5958 CERTIFICATE OF DEATH

05949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Pike George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Pike George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethelworth</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethelworth</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "At home"		d. STREET ADDRESS <i>14625 R. St. N.C.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>August</i>	Middle <i>J</i>	Last <i>Wahl</i>	4. DATE OF DEATH Month <i>MAY</i>	Month <i>7</i>	Day <i>7</i>	Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 11-1889</i>		9. AGE (In years last birthday) <i>70</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction Co.</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Wahl</i>		14. MOTHER'S MAIDEN NAME <i>Matilda Wahl Muir</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-12-2157</i>		17. INFORMANT <i>Robert T. Wahl</i>		Address <i>79 1/2 Halsted St., Westgate, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>180X</i> DUE TO <i>Adenosarcoma Kidney</i> INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) <i>Colmar Manor, Md.</i>	(State) <i>MD</i>	
21. I certify that I attended the deceased from <i>3/26</i> , 19 <i>58</i> , to <i>MAY 7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>May 7</i> , 19 <i>59</i> , and that death occurred at <i>1:15 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>940-25th Street, N.W., May 7, 1959</i> DATE SIGNED							
ACTUAL SIGNATURE <i>Danny N. Carlson</i>		M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>5-9-59</i>	22b. DATE THEREOF <i>5-9-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft Lincoln</i>		22d. LOCATION (City, town, or county) <i>Colmar Manor, Md.</i>		(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm Lee's Sons Co. Wash 2 DC.</i>		ADDRESS <i>300-4th st N.E.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 11 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

05950

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georgd							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 1904 Amherst Road							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Anna		First Anna	Middle L	Last West	4. DATE OF DEATH Jan. 28, 1876	Month May	Day 21	Year 1876					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1876		9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John S Johnson		14. MOTHER'S MAIDEN NAME Grace Morgan											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT									
												Address Mt. Rainier Frances Moore, Daughter, 3722 36th, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO		<i>Acut by oca de al clupar deu.</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hughesville		(County) Maryland	(State) Md.	
21. I certify that I attended the deceased from Aug 12 , 19 59 , to Aug 21 , 19 59 , that I last saw the deceased alive on Aug 24 , 19 59 , and that death occurred at M. from the causes and on the date stated above.													
ACTUAL SIGNATURE Aaron Deitz		ADDRESS (Street, city or town, state) Hughesville										DATE SIGNED 5/21/59	
PHYSICIAN'S NAME (Type) Aaron Deitz													
22a. BURIAL, CREMATION REMOVAL (SPECIFY) Burial 5-23-59		22b. DATE THEREOF 5-23-59		22c. NAME OF CEMETERY OR CREMATORIAL Presbyterian		22d. LOCATION (City, town, or county) Darnestown, Md		(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Not at Allthing & Saal		ADDRESS 318		24a. REC'D BY REGISTRAR DATE MAY 25 '59		24b. REGISTRAR'S SIGNATURE Charles L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should remain with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		5922 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		Reg. Dist. No.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg		b. COUNTY Prince Georges	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 3708 52 Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Anna	Middle Marie	Last White	4. DATE OF DEATH May 17	Month May	Day 17	Year 19 58
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 6/4/94	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Gottfried J Aebersold				14. MOTHER'S MAIDEN NAME Anna ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Jospeh White Husband		Address Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 343 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 6 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/14 , 19 59 to 5/17 , 19 59 , that I last saw the deceased alive on May 17 , 19 59 , and that death occurred at 8:10A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 3503 Runy St					
ACTUAL SIGNATURE <i>Norman Donat Comeau</i>		DATE SIGNED 5/17/59					
PHYSICIAN'S NAME (Type) Norman Donat Comeau		<i>MT Rainier Md</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/59		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE MAY 21 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

STATE DEPARTMENT OF HAWAII - SALINAS
CERTIFICATE OF DEATH

DEATH CERTIFICATE
SALINAS, HAWAII

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5923 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05954

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 10a, Film G-243 5/28/59.c.

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

& 10b

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

5 hours

XXXX.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
May

Day
16

Year
1959

5. SEX

Male

6. COLOR OR RACE

colored

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

4-24-19

9. AGE (In years
last birthday)

40 yrs.

10. IF UNDER 1YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Laborer Cement Mason

10b. KIND OF BUSINESS OR INDUSTRY

Construction Worker

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Parker Williams, Sr.

14. MOTHER'S MAIDEN NAME

Emma Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Louise Williams; same address as # 2.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Hemorrhage and shock

INTERVAL BETWEEN
ONSET AND DEATH

981X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Laceration of femoral artery

(c)

Shotgun wound of leg

2 MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Shot in leg by another person.

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 1:00 AM 5-16-59

20d. INJURY OCCURRED

White Not white

at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

Tavern

Cedar Heights Pr. Geo. Md.

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Nutrol causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John T. Maloney, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

May 16, 1959

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

5/21/59

22c. NAME OF CEMETERY OR CREMATORIUM

Church CEMETERY

22d. LOCATION (City, town, or county). (State)

TRIANGLE Virginia

23. FUNERAL DIRECTOR'S SIGNATURE

John T. Rhines & Co.

ADDRESS

24a. REC'D BY REGISTRAR

MAY 19 '59

24b. REGISTRAR'S SIGNATURE

Collins & Krause

3015-12 STREET N.E. WASH. D.C.

WISCONSIN STATE DEPARTMENT OF HIGHER EDUCATION
WISCONSIN EXAMINER'S CERTIFICATE OF DEATH

F

1971

1971

As per death certificate issued

on date of death

cause of death

place of death

name of deceased

name of informant

name of informant

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5924 CERTIFICATE OF DEATH

Reg. Dist. No.

05955

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
Prince Georges County MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cheverly	8 days	X Cottage City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Prince Georges General Hospital		3802	40th A venue
3. NAME OF DECEASED (Type or print)		First	Middle
Bertha			Last
4. DATE OF DEATH	Month	Day	Year
Wood	May	25	19 59
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10/19/76
10a. USUAL OCCUPATION (Give kind of work done during last 6 months, wife, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Own Home	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Pennsylvania		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Breezy		Mary Pearson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		None Frederick L. Wood Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral hemorrhage 5-wks.	
331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Arteriosclerosis, generalized	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 18, 19 59, to May 25, 19 59, that I last saw the deceased alive on May 25 1959, 19 59, and that death occurred at 7 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE James B. Bassett M.D.		DATE SIGNED 1959	
PHYSICIAN'S NAME (Type) James B. Bassett M.D.		Signature Marlowe	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 5/26/59	
22c. NAME OF CEMETERY OR CREMATORIAL Plymouth		22d. LOCATION (City, town, or county) (State) Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave.	
		Hyattsville, Maryland	
24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

WISCONSIN STATE DEPARTMENT OF HEALTH - SANITATION

CERTIFICATE OF DEATH

DECEASED PERSON

SSN

DATE OF BIRTH

DEATH DATE

DECEASED PERSON'S NAME
ADDRESS
CITY, STATE, ZIP CODE

DECEASED PERSON'S RELATIONSHIP TO DECEASED PERSON
DECEASED PERSON'S AGE
DECEASED PERSON'S GENDER
DECEASED PERSON'S RACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5959 CERTIFICATE OF DEATH

Reg. Dist. No.

05956

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Maryland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Heights</i>		c. LENGTH OF STAY IN lb <i>4 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Heights</i>		d. STREET ADDRESS <i>17204 Climbust Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7204 Climbust Street</i>		d. STREET ADDRESS <i>17204 Climbust St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Margaret</i>	Middle <i>Jessie</i>	Last <i>Jessie</i>	4. DATE OF DEATH	Month <i>May</i>	Day <i>18</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>June 12 1900</i>	9. AGE (In years last birthday) yrs. <i>58</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Andrew Martinich</i>		14. MOTHER'S MAIDEN NAME <i>Theodore Neumann</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Anthony J. Jurisic same as above</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> INTERVAL BETWEEN DUE TO <i>260x</i> ONSET AND DEATH <i>immediately</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> 2 yrs.— (c) <i>Diabetes Mellitus</i> 5 yrs.—							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-2</i> , <i>1959</i> , to <i>May 18</i> , <i>1959</i> , that I last saw the deceased alive on <i>May 17</i> , <i>1959</i> , and that death occurred at <i>615 P.M.</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>Silver Hill Rd</i>							
ACTUAL SIGNATURE <i>John P. D'Angelo M.D.</i> DATE SIGNED <i>5-18-59</i>							
PHYSICIAN'S NAME (Type) <i>John P. D'Angelo M.D.</i>		<i>Silver Hill, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-22-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Joseph's</i>		22d. LOCATION (City, town, or county) <i>Hazeltown, Pa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert W. Knapp</i>		ADDRESS <i>131-1128</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 20 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Anna</i>	

